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| ***Click here to enter a date*** |
| ***Click here to enter First and Last Name*** |
| ***Click here to enter Street Address***  |
| ***Click here to enter Agency City, State Zip*** |
| **Subject: Family and Medical Leave – Insufficient Medical Certification** |
| We have received the Health Care Provider Certification Form for family and medical leave on ***Click here to enter a date***, we are unable to verify if the leave qualifies under the Federal Family and Medical Leave Act (FMLA) and the Oregon Family Leave (OFLA) because your healthcare provider left the following parts of Section II blank or provided insufficient information. |

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| Enclosed is your medical certification form. If your healthcare provider did not complete all relevant parts of Section II, please return the form to your healthcare provider to be completed. Return the form to the agency within seven days of the notification ***– by – Click here to enter a date.*** The agency will pay for any uninsured expenses related to this form. Follow the agency’s policy regarding reimbursement and submit receipts for the uninsured medical expenses related to obtaining this certification.The law requires the agency to inform you that should you fail to provide a sufficient and complete medical certification, your FMLA and/or OFLA leave may be denied. The law also requires the agency to inform you that the agency may recoup any insurance premium payments made on your behalf where you are not entitled to insurance.Please contact us if you have any questions concerning your Family and Medical Leave entitlements. |
| ***Click here to enter Your Name – Signature Line*** |
| ***Click here to enter Your Position or Title Name*** |
| PHONE: ***Click here to enter Phone Number(s)*** |
| FAX: ***Click here to enter Fax Number*** |