



HEALTH CARE PROVIDER CERTIFICATION
**** Family Member's Serious Health Condition Form ****
Family and Medical Leave
Oregon Department of Corrections

This form is used to provide certification per FMLA and OFLA regulations and law.

Section I: Employee Completes this Section

Employee's name: _____

Patient's name: _____

The patient is my (Please circle one):

spouse	parent	child (age ____)	same sex domestic partner	parent-in-law
grandparent	grandchild	parent of domestic partner	child of a domestic partner (age ____)	

Section II: Health Care Provider Completes this Section

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. **Please be sure to sign the form on the last page and fax completed form to (503) 362-2078.**

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? No Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? No Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): _____

3. Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ___ No ___ Yes.

Explain the care needed by the patient and why such care is medically necessary:

Estimate the employee's dates of absence from work: _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

If so, estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

During this time, will the patient need care? ___ No ___ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities requiring care on an intermittent or reduced schedule basis? ___No ___Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ___ No ___ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

Signature of Health Care Provider

Date

Please return this form to the patient or FAX to the Department of Corrections Human Resources FMLA/OFLA at (503) 362-2078.