**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.

<table>
<thead>
<tr>
<th>Section I: Employee Completes this Section</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee’s name:</strong> __________________________</td>
</tr>
<tr>
<td><strong>Patient’s name:</strong> __________________________</td>
</tr>
</tbody>
</table>

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 ___)

<table>
<thead>
<tr>
<th>Section II: Health Care Provider Completes this Section</th>
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</table>

**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.