Certification of Health Care Provider for Employee's Serious Health Condition

Employer name and contact:

City of Salem, Human Resource Department
555 Liberty St. SE, Room 225
Salem Oregon 97301

Phone: 503-588-6162 Fax: 503-588-6170

Employee's job title: _____

Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to your medical provider. FMLA/OFLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA/OFLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA/OFLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA/OFLA request. Your employer must give you at least 15 calendar days to return this form.

Your name:

_____

First Middle Last

For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under FMLA/OFLA. Answer fully and completely all applicable parts. 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/OFLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

Provider's name and business address: _____

_____

_____

Type of practice / medical specialty: _____

_____

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

MEDICAL FACTS Mark below as applicable:

1. Approximate date condition commenced: _____
2. Probable duration of condition: _____
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ___Yes. If so, dates of admission: _____

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

   _____
5. Will the patient need to have treatment visits at least twice per year due to the condition?

   ___No ___ Yes
6. Was medication, other than over-the-counter medication, prescribed? ___No ___Yes
7. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?____No ____Yes
8. If so, state the nature of such treatments and expected duration of treatment:

   _____
9. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

Use the above listed information provided by the employer to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

1. Is the employee unable to perform any of his/her job functions due to the condition:

   ____ No ____ Yes. If yes, identify the job functions the employee is unable to perform:_____

   _____

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

_____

_____

AMOUNT OF LEAVE NEEDED

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes

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

   Beginning Date: _____ Ending Date: _____

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes

   If yes, are the treatments or the reduced number of hours of work medically necessary?

   ___No ___Yes

3. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

4. Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from _____ through _____

5. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes

6. Is it medically necessary for the employee to be absent from work during the flare-ups?

   ____ No ____ Yes. If yes, please explain: _____

7. 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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**