Certification of Health Care Provider for Family Member's Serious Health Condition

Employer name and contact:

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

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

For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to your family member or his/her medical provider. The 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 to care for a covered family member with a 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 to your employer.

Your name:

_____
First Middle Last

Name of family member for whom you will provide care:

_____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA/OFLA 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/OFLA coverage. Limit your responses to the condition for which the patient needs leave. Page 4 provides space for additional information, should you need it. 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:(_____)_____

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 yes, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy? ___No ___Yes

If yes, expected delivery date: _____

3. 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):

_____

_____

_____

_____

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

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: _____

_____

_____

_____

_____

_____

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

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

_____

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

_____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? _____ No ____ Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week

From _____ through _____

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

_____

_____

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____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: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**