

Oregon and Federal  
Family and Medical Leave  
**Health Care Provider Certification**

This form is to be completed by physician or other health care provider and returned to the employee or:

Information sought on this form relates only to the condition for which the employee is taking leave.

Employee's Name: \_\_\_\_\_

Patient's Name (if different from employee): \_\_\_\_\_

1. On the reverse of this sheet is a description of various "serious health condition" categories that qualify under the Family and Medical Leave Acts. Please check appropriate category or categories:

- 1-Hospital care       3-Pregnancy and/or prenatal care       5-Perm/long-term condition requiring supervision  
 2-Absence plus treatment       4-Chronic condition requiring treatment       6-Multiple treatments (non-chronic condition)

2. Provide a description of the medical facts that support your certification and explain how they meet the criteria of the category:

\_\_\_\_\_

3. Approximate date condition began and probable duration: from \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_

4. Probable duration of patient's present incapacity (if different): from \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_

5. If this is a chronic condition or pregnancy, is the patient presently incapacitated (see reverse side for definition)?

Yes     No    If yes, duration and frequency of episodes of incapacity: \_\_\_\_\_

6. Will it be necessary for the employee to take leave only intermittently or to work on a less than full-time schedule basis because of the condition or treatment?     Yes     No    If yes, duration: \_\_\_\_\_.

Frequency:  One to two days per month     Two to three days per month     Three to four days per month

Other: Please explain how the employee will use leave intermittently or work a less than full-time schedule, being as specific as possible including frequency and duration of absences:

\_\_\_\_\_

6. If the patient requires a regimen of treatment, what is the nature of and description of the treatments, estimated number of treatments, and intervals between treatments (see reverse side for definition)? \_\_\_\_\_

\_\_\_\_\_

What are the actual or estimated dates of visits for treatment, or frequency of visits for treatment? \_\_\_\_\_

What is the duration of each treatment and any period required for recovery? \_\_\_\_\_

**7. If this certification relates to the employee's seriously ill family member(s), also complete the following:**

a. Does the patient require assistance for basic medical or personal needs, safety, or for transportation?  Yes     No

b. If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery?

Yes     No

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration and frequency of this need: \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Physician/ Practitioner

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Physician/ Practitioner

\_\_\_\_\_  
Type of Practice/ Field of Specialization

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

## HEALTH CARE PROVIDER CERTIFICATION form (continued)

Federal and Oregon Family and Medical Leave Acts

---

### Definition of a "Serious Health Condition":

A "serious health condition" is defined as an illness, impairment, physical or mental condition that involves one of the following:

**1. Hospital care –**

Inpatient care (i.e., overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

**2. Absence plus treatment –**

A period of incapacity of more than three consecutive calendar days (including any period of incapacity or subsequent treatment relating to the same condition), that also involves:

(a) Treatments two or more times by a licensed healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider, *or*

(b) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under supervision of the healthcare provider.

*(1) Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment DOES NOT include routine physical, dental, or eye examinations.*

*(2) A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment DOES NOT include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or any other similar activities that can be initiated without a visit to a healthcare provider.*

**3. Pregnancy –**

Any period of incapacity due to pregnancy, pregnancy-related illness, or for prenatal care.

**4. Chronic conditions requiring treatments –**

A chronic serious health condition is one which:

(a) Requires periodic visits for treatment by a healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

**5. Permanent/ long-term conditions requiring supervision –**

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include Alzheimer's, a severe stroke or the terminal states of a disease.

**6. Multiple treatments (non-chronic conditions) –**

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either of restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

**Definition of "Incapacitated":** Inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

**Directions regarding "Regimen of treatment" (question 5):** If the patient is under your supervision, provide a general description of such regimen, such as prescription drugs or physical therapy requiring special equipment. If the treatments will be provided by another provider of health services, such as a physical therapist, please state the nature of the treatments.