Oregon Family Medical Leave

Health Care Provider Certification

This form is to be completed by a health care provider and returned to the employee.
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. Please check the appropriate category of leave:

☐ 1-Pregnancy and/or prenatal care (Any period of incapacity due to pregnancy or pregnancy-related illness before or after the birth of the child). This category includes childbirth or pregnancy termination, or a period of absence for prenatal care, including fertility or infertility treatment.)
☐ 2-Sick Child Leave (Any illness, injury, or condition (serious and non-serious health conditions) of the employee's child requiring home care.)

2. Describe 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?

☐ Yes ☐ No If yes, please provide the duration and frequency of episodes of incapacity:

_____

6. Will it be necessary for the employee to take:

Full-time leave? ☐ Yes ☐ No If yes, from ___/___/___ to ___/___/___

Intermittent leave or work on a less-than-full-time schedule? ☐ Yes ☐ No If yes, from ___/___/___ to ___/___/___

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 regarding frequency and duration of absences:

_____

7. 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 of this sheet for definition)? _____

_____

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

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

8. If this certification relates to the employee's need to care for the employee's child, complete the following:

a. Does the patient require assistance for basic medical or personal needs, safety, or 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*