Multnomah County - CERTIFICATION OF HEALTH CARE PROVIDER
Family and Medical Leave (FMLA and OFLA)

FAMILY MEMBER - SERIOUS HEALTH CONDITION

TO BE COMPLETED BY EMPLOYEE

Employee's Name:	Patient is your:
Patient's Name:	Patient's date of birth:

By signing, I acknowledge that any leave I use will be to care for the family member certified on this form.

_______________________________________ _____________________________
Employee Signature Date

When completed, send to: *Leave Administrator, Multnomah County Employee Benefits, 501 SE Hawthorne, Ste 400, Portland OR 97214. Confidential fax: 503-988-6257. Email: leave.information@multco.us*

FMLA/OFLA permits an employer to require submission of timely, complete, and sufficient medical certification to support a request for FMLA/OFLA leave. A 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 the FMLA/OFLA request. **THIS FORM IS TO BE COMPLETED BY THE HEALTH CARE PROVIDER.**

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The family member of your patient has requested leave under FMLA/OFLA. Answer fully and completely all applicable parts of this form. Your answers 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.** Please be sure to sign the form on the last page.

Print Provider's Name and License Held: ____

Business Address: ____

Type of Practice/Medical Specialty: ____________________________________Phone: _________________________

MEDICAL FACTS

1. State approximate date condition commenced: ____
2. Probable duration of condition from the date condition commenced: ____________________________________
3. Was or will the patient be admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes **If yes**, date(s) of admission: ____
4. Date(s) you treated the patient for condition: ____
   (Dates of treatment for this condition in the past 12 months.)
5. Has medication, other than over-the-counter medication, been prescribed? ☐ No ☐ Yes
6. Are treatments scheduled at least twice per year due to the condition? ☐ No ☐ Yes
7. 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: _______________
   ____
8. Describe relevant **medical facts**, 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 (if pregnancy, provide estimated due date): ____
   ____
   ____

MEDICAL CARE NEEDED *(Childcare is not a qualifying condition.)*
Care for your patient, which will be provided by the employee seeking leave, may include the following:

- medical care
- transportation
- hygienic care
- physical care
- nutritional care
- psychological care
- safety

Pre-scheduled Leave

9. Will the patient be incapacitated, requiring *continuous and/or intermittent* care? ☐ No ☐ Yes

If yes for Continuous Care: Estimate beginning and ending dates: From: __________ (date) **through** __________ (date)

If yes for Intermittent Care: Estimate the number of hours per day care is needed on an intermittent basis, *not including time for appointments, continuous leave or flare-ups*:

Hours per day: ________ **and** days per week: ________ From: ______________ (date) **through** _______________ (date)

Provide an explanation of the **care needed** by the patient during either continuous or intermittent care:

____

____
(Do **not** provide information for scheduled appointment(s).)

Appointments

10. Will the patient **require assistance** for follow up treatments, including time for recovery? ☐ No ☐ Yes

If yes, estimate treatment(s) schedule:
Patient has scheduled appointments on ____and/or

Patient may require assistance to appointments from: _______________ (date) **through** _______________ (date)

Frequency: ________ appointments per ________ week(s) **OR** ________ month(s), lasting ________ hours.

Flare-ups/Unscheduled Care

11. Will the condition cause episodic **flare-ups** which periodically prevent the patient from participating in normal daily activities and where care from the family member(s) is required during the flare-ups? ☐ No ☐ Yes

If yes, based upon the patient's medical history and your knowledge of the medical condition, **estimate** the frequency of the flare-ups and the duration of related incapacity that the patient may have (e.g. 1 episode every 3 months lasting 1-2 days from January 1 through July 30):

Patient may have flare-ups from: ________________ (date) **through** ________________ (date)

Frequency: ___________ episodes per ___________ week(s) **OR** ___________ month(s)

Durations: ___________ hours or ___________ day(s) per episode

NOTE: An estimate must be provided. Using unknown or indeterminate will not provide sufficient information to be able to grant leave for flare-ups. If the condition changes, treating providers may update their estimated frequency and duration.

Explain the **care needed** by the patient during flare-ups (see bulleted points at top of page):

____

____
(Flare-ups are **not** appointments or pre-scheduled leave.)

ADDITIONAL INFORMATION

____

____

____ ____
Signature of Health Care Provider Date

"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 employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

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