EMPLOYEE SERIOUS HEALTH CONDITION

Employee's Name:	
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*	

To receive FMLA/OFLA protection for leave, Multnomah County must receive a timely, complete, and sufficient medical certification to support a request for FMLA/OFLA leave. This information 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 HEALTH CARE PROVIDER: 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 <u>duration</u> 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): _____

   _____

   _____
9. If the employer does not 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. Is the employee unable to perform any of his/her job functions with the condition? ☐ No ☐ Yes **If yes**, identify the job functions the employee is unable to perform: _____

   _____

AMOUNT OF LEAVE NEEDED

Full Time Leave

10. Will the employee be incapacitated for a **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:

    From: _____ **through** _____
    (date) (date)

Reduced Schedule

11. Will the employee need to work **part-time** or a reduced schedule due to the employee's medical condition? ☐ No ☐ Yes

    If yes, estimate the part-time or reduced work schedule the employee is able to work:

    Hours per day: _____ **and** days per week: _____ From: _____ **through** _____
    (date) (date)

Appointments

12. Will the employee need to attend follow-up treatment **appointments** due to the employee's medical condition? ☐ No ☐ Yes

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

    Patient may have appointments from: _____ **through** _____
    (date) (date)
    Frequency: _____ appointments per _____ week(s) **OR** _____ month(s), lasting _____ hours.

Flare-ups/Unscheduled Leave

13. Will the condition cause episodic **flare-ups**, periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes

    If yes, explain why it is medically necessary for the employee to be absent from work during the flare-ups:
    _____

    _____
    (Flare-ups are **not** appointments, continuous leave or pre-scheduled leave.)

    And 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: _____ **through** _____
    (date) (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.

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."