

CERTIFICATION BY HEALTHCARE PROVIDER

FAMILY MEMBER'S HEALTH CONDITION

RETURN TO: Human Resources, University of Oregon, 677 East 12th Ave., Suite 400, Eugene OR 97403-5210 - fax 541-346-2548

1. Employee's Name: _____

2. Family Member/Patient's Name (and relationship to employee): _____

3. If the patient's condition¹ qualifies under any of the following categories for serious health conditions, please check them. See back for a definition of each category. If the leave is related to Oregon Sick Child Leave please skip to 3b.

_____ 1. Hospital Care

_____ 4. Chronic Conditions Requiring Treatments

_____ 2. Absence Plus Treatment

_____ 5. Permanent/Long-term Conditions Requiring Supervision

_____ 3. Pregnancy (Incapacity)

_____ 6. Multiple Treatments (Non-Chronic Conditions)

_____ None Apply

_____ 7. Injured or Ill Servicemember

3a. Describe the medical facts that support the category you checked:

3b. Describe the medical facts that support leave under Oregon Sick Child Leave.

4. Date patient's condition commenced: _____

5. Estimated Duration of patient's incapacity: _____

6. Does the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? Yes _____ No _____

7. After review of the employee's signed statement below, is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include emotional support.) Yes _____ No _____

8. Estimate the period of time care is needed or the employee's presence would be beneficial:

TO BE COMPLETED BY THE EMPLOYEE REQUESTING FAMILY LEAVE

Please provide the following information: A description of the care you will provide, the estimated duration of your leave, and a leave schedule that outlines how your leave will be taken. (Continuous, intermittent, or a reduced work schedule)

Employee Signature: _____

Date: _____

9. Print name of Healthcare Provider: _____

Date: _____

10. Print Type of Practice (Specialization, if any) _____

Signature of Healthcare Provider: _____

¹ Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA/OFLA leave.

A “**Serious Health Condition**” means an illness, injury, impairment, or physical or mental condition that involves one of the following categories:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

- a. A period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
- (1) **Treatment³ two or more times** by health care provider, by a nurse or physician’s assistant under direct supervision of health care provider, or by a provider of health care services (e.g. physical therapist) under orders of , or on referral by, a health care provider; **OR**
 - (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment⁴** under the supervision of a health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

- a. Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider.
- b. Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
- c. May cause **episodic** rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **incapacity** which 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 health care provider**. Examples include Alzheimer’s, a severe stroke, or the terminal stages 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 health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **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).

NOTE TO CARE PROVIDER: 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. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s 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.

² “**Incapacity**,” for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

³ Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, or dental examinations.

⁴ 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, and other similar activities that can be initiated without a visit to a health care provider.