# Jefferson County Education Service District

Code: GCBDA/GDBDA-AR(5)
Adopted: 1/14/21

## OFLA Medical Certification

(To be completed by health care provider)

Certification of Health Care Provider (Oregon Family Leave Act)

1. Employee's Name:

2. Patient's Name (if different from employee):

3. Does the patient's condition qualify as a serious health condition under any of the following reasons listed? ☐ Yes ☐ No

If yes, please check the applicable reason(s):

☐ Inpatient care ☐ Continuing treatment ☐ Chronic conditions ☐ Multiple treatments
☐ Permanent, long-term or terminal conditions ☐ Pregnancy and prenatal care

4. Provide a brief statement as to how the medical facts meet the criteria of the category you checked above.

5. What is the common name of the medical condition (e.g., cancer, diabetes, stroke, etc.)?

6. Please state the approximate date the condition commenced: , and the probable date the employee will be able to return to work: .

7. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition? ☐ Yes ☐ No

If yes, give the probable duration:

8. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will miss work intermittently, please indicate dates and intervals of treatment, length of treatment, frequency of treatment, recovery time from treatment.

If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments and the provider if known.

9. If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

10. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment).

11. Is leave required to care for a family member with a serious health condition? ☐ Yes ☐ No

If the family member will need care only intermittently or on a part-time basis, please indicate the probable duration of this need.

12. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? ☐ Yes ☐ No

If yes, briefly describe assistance required

Health Care Provider Date

Address Telephone Number

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

Employee Signature Date