CERTIFICATION OF HEALTH CARE PROVIDER

This form is to be completed by the Health Care Provider:

Please provide the requested information below in relation only to the condition for which the employee is taking leave

NOTE – THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT CONSENT OF THE PATIENT.

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 tests, the fact that an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive services.

1. Employee Name (Complete # 1-7 only below)	**2. Patient's Name (if other than employee): (Do not complete #6 or #7)**

3. On the reverse side is a description of what is meant by a "serious health condition" under both the federal and Oregon family medical leave laws. Does the patient's condition qualify under any of the categories described? ☐ No ☐ Yes – If yes, please check the appropriate category below:

☐ Inpatient care ☐ Chronic condition requiring treatments ☐ Multiple treatments (non-chronic condition) ☐ Pregnancy
☐ Permanent/long-term condition requiring supervision ☐ Absence plus treatment (Unable to perform work of any kind)

4. **Date medical condition or need for treatment commenced (mm/dd/yyyy)**	**5. Probable duration of medical condition or need For treatment (mm/dd/yyyy)**

6. If the certification is for the serious health condition of the employee, please answer the following:

☐ Unable to perform work of any kind **As of what date: _____**
☐ May perform regular work without restrictions **As of what date: _____**
☐ Perform work with restrictions **As of what date: _____**

TEMPORARY RESTRICTIONS ARE:

☐ Reduced work schedule of _____ hours per day
☐ No bending/stooping or twisting of back
☐ No kneeling or Squatting
☐ No overhead work with (right/left) _____
☐ No use of ladders/foot stools above _____ height
☐ Avoid Stairs
☐ Unable to operate a vehicle or machinery (circle)
☐ Ergonomic Evaluation Requested
☐ Other Restrictions: _____

☐ Avoid reaching above shoulder level with (right/left) _____
☐ No pushing or pulling more than _____ pounds
☐ No Lifting over _____ pounds
☐ No standing more than _____ minutes at a time
☐ No sitting more than _____ minutes at a time
☐ No lifting more than _____ pounds overhead
☐ No repetitive motion of _____ for _____ minutes at a time
☐ Should take a short break every _____ minutes, and/or _____ hours to change positions for activity _____

7. Does the employee need intermittent leave or a reduced work schedule:

a. ☐ Yes ☐ No Is it medically necessary for the employee to be off work on an intermittent basis or work less than the employee's normal work schedule in order to deal with a serious health condition?

If YES, please clearly detail the number of hours each day, per week/month medically necessary for the employee to be off work for doctor's appointments, medical treatments, or other health provider services:

_____ hour(s) per day, _____ day(s) per week/month/year for _____ probable duration.
(circle)

8. If the certification is for the care of the employee's *family member*, please answer the following:

a. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? ☐ Yes ☐ No

b. Does the condition warrant the participation of the employee? (Participation may include psychological comfort and/or arranging for third-party care for the family member). ☐ Yes ☐ No

9. Please clearly estimate the period of time each day/week care is needed during which employee's presence would be beneficial:

_____ hour(s) per day, _____ day(s) per week/month for _____ probable duration
(circle)

Name of Health Care Provider (please print):	**Signature of Health Care Provider:**
Type of Practice:	**Date:**
Address:	**Phone Number: ( )**

Please complete and return to: Southern Oregon University Human Resource Services, Attention: Michele Barlow, Assistant Director of HR/Accessibility Coordinator, 1250 Siskiyou Blvd, Ashland, OR 97520 Phone: (541) 552-8119 Fax: (541) 552-8508
Email: barlowm@sou.edu

DEFINITION (AND CATEGORIES) OF SERIOUS HEALTH CONDITION

Family Medical Leave Act (FMLA) and Oregon Family Leave Act (OFLA)

NOTE TO CARE PROVIDER:

Definition of Serious Health Condition: An illness, injury, impairment, or physical or mental condition that involves one of the following:

c. Hospital Care

Inpatient care (I.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[1] or subsequent treatment in connection or consequent to such inpatient care.

d. Absence Plus Treatment

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. **Treatment[2] two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders or, or on referral by, a health care provider; OR
2. Treatment by a health care provider on **at least once occasion** which results in a **regimen of continuing treatment[3]** under the supervision of a health care provider.

e. Pregnancy

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

f. 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.).

g. Permanent/Long-Term Conditions Requiring Supervision

A period of incapacity which is **permanent or long-term** due to 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.

h. 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).

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[1] Incapacity, for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular activities due to the serious health condition, treatment therefore, or recovery therefrom.

[2] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine examinations, eye examinations, or dental examinations.

[3] 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 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.