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