Three Rivers School District

8550 New Hope Rd • PO Box 160 • Murphy, OR 97533

FMLA MEDICAL CERTIFICATION FORM

Medical Certification Form
Certification of Health-care Provider
(Family and Medical Leave Act of 1993)

1. Employee's Name:_____

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

3. The attached sheet describes what is meant by a "serious health condition" or a serious illness or injury of a covered service member under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

   (1)_____(2)_____(3)_____(4)_____(5)_____(6)_____None of the above_____

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5a. State the approximate date the condition commenced and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different):

5b. 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 (including treatment described in item 6 below):

5c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

6a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of a treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known and period required for recovery if any:

6b. 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.

6c. 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):

_____

[1]Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.
[2]"Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regularly daily activities due to the serious health condition, treatment therefore or recovery therefrom.

7a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? _____

7b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? _____ If yes, please list the essential functions the employee is unable to perform:

7c. If neither 7a. nor 7b. applies, is it necessary for the employee to be absent from work for treatment? _____

8a. 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? _____

8b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?_____

8c. If the patient will need care only intermittently or on a part-time basis, please indicate the probably duration of this need:

9. Was the serious illness or injury sustained in the line of duty, while on active duty, that may render the person medically unfit to perform the duties of the person's office, grade, rank, or rating?

_____ _____
Signature of Health-care Provider Type of Practice

_____ _____
Address Phone 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

A "serious health condition" means an illness, injury, impairment or physical or mental condition of an employee or family member that involves one of the following:

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

2. **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:
   a. Treatment[3] 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 of, or on referral by, a health-care provider; or
   b. Treatment by a health-care provider on at least one occasion which results in a regimen of continuing treatment[4] under the supervision of the health-care provider.

[3]Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye 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. An exception to this definition of regimen could occur when an employee suffers from a minor illness generally treated with over-the-counter medication, bed rest and intake of fluids so long as the employee is incapacitated for more than three days and is under continuing treatment by a health-care provider for the specific ailment.

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 Condition 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 (Nonchronic 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).

A "serious illness or injury of a covered service member" means an injury or illness incurred by the member in the line of duty, while on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

ADOPTED:
REVIEWED: New Policy