

Certification of Health Care Provider Form

Portland Community College Human Resources

PCC Employee/Patient's Name _____

Social Security Number _____

Does the patient's condition¹ qualify under the Family & Medical Leave Act (FMLA) as one of the "serious health conditions" described below? If Yes, indicate the number of the condition: _____ . No _____

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition 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 incapacity² 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 of period of incapacity relating to the same condition) that also involves:

- (1) Treatment³ of 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 order 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 the health care provider.

3. Pregnancy

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

4. Chronic Conditions Requiring Treatments

A chronic condition that:

- (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 there from) 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 days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

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 regular daily activities due to the serious health condition, treatment there for, or recovery there from.

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

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 or bed-rest, drinking fluids, exercise and other similar activities that can be initiated without a visit to a health care provider.

1. Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories listed on page 1 of this form.
2. 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 if different.
3. Will it be necessary for the employee to work only intermittently or to work less than a full schedule as a result of the condition? If Yes, give probable duration _____ No _____

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

4. 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 treatment on an intermittent or part-time basis, also provide the interval between such treatments, the actual or estimated dates of treatment if known, and period required for recovery, if any.

Number of treatments: _____ Recovery period required: _____

Intervals between treatments: _____ Dates: _____

If a regimen of continuing treatment is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy):

5. The employee is absent from work due to: Unable to perform work of any kind
 Medically necessary treatment Unable to perform certain essential job functions

Physician Signature

Date

Address

Telephone

Type of Practice

Upon completion of this form, please fax to 503-286-0410, or mail to

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Human Resources – Benefits
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