



City of Oak Harbor

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

Section I: For Completion by EMPLOYER

Date:

Employer Name: City of Oak Harbor 865 SE Barrington Dr, Oak Harbor, WA 98277	Employer Contact Information: Human Resources - OHHR@oakharbor.org Office: 360-279-4509 or 4518 FAX: 360-279-4559
Employee's Job Title:	Employee's Regular Work Schedule:
Employee's Essential Job Functions: See Job Description included.	Check if job description is attached <input checked="" type="checkbox"/>

Section II: For Completion by EMPLOYEE

Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. 825.305(b).

Employee's Name (First, Middle, Last):	Please return info to HR by:
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Section III: For Completion by the HEALTH CARE PROVIDER

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. **Please be sure to sign the form on the last page.**

Provider's Name:	Provider's Business Address:	
Type of Practice / Medical Specialty:		
Telephone Number: ()	Fax Number: ()	Email address:

Part A: MEDICAL FACTS

1. Approximate Date Condition Commenced:	Probable Duration of Condition:
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Mark below as applicable

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date(s) of admission:
Date(s) you treated the patient for condition:	Will the patient need to have treatment visits at least twice per year due to the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was medication, other than over-the-counter medication, prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, state the nature of such treatment and expected duration of treatment:	

2. Is the medical condition pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, expected delivery date:
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3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? Yes No

If yes, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Part B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment recovery? Yes No

If yes, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? Yes No

If yes, are the treatments or the reduced number of hours of work medically necessary? Yes No

Estimate treatment schedule, if any, including the dates of any scheduled appointments at the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day _____ days per week from: _____ through: _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? Yes No

Is it medically necessary for the employee to be absent from work during the flare-ups? Yes No

If yes, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of the flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s) Duration: _____ hour(s) or _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider: _____ Date: _____

Please Print Name: _____