



# City of Oak Harbor

## Certification of Health Care Provider for Family

### Member's Serious Health Condition (Family and Medical Leave Act)

#### Section I: For Completion by EMPLOYER

Date:

|   |  |
|---|--|
| Employer Name:<br><b>City of Oak Harbor</b><br>865 SE Barrington Dr, Oak Harbor, WA 98277 | Employer Contact Information:<br><b>Human Resources - OHHR@oakharbor.org</b><br>Office: 360-279-4509 or 4518 FAX: 360-279-4559 |
|---|--|

#### Section II: For Completion by EMPLOYEE

Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a 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.

|   |                                       |   |  |
|---|---------------------------------------|---|--|
| Employee's Name (First, Middle, Last):  |                                       | <b>Please return info to HR by:</b>                 |  |
| Name of family member for whom you will provide care (First, Middle, Last):                     | Relationship of family member to you: | If family member is son or daughter, date of birth: |  |
| Describe care you will provide to your family member and estimate leave needed to provide care: |                                       |   |  |
| Employee Signature:   |                                       | Date:   |  |

#### Section III: For Completion by the HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs 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:<br>( )              | Fax Number:<br>( )           | Email address: |  |

#### Part A: MEDICAL FACTS

|  |                                 |
|--|---------------------------------|
| 1. Approximate Date Condition Commenced: | Probable Duration of Condition: |
|--|---------------------------------|

#### 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)?  Yes  No

If yes, state the nature of such treatment and expected duration of treatment:

2. Is the medical condition pregnancy?  Yes  No

If yes, expected delivery date:

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (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: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:**

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

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

During this time, will the patient need care?  Yes  No

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery?  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:

Explain care needed by patient, and why such care is medically necessary:

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  Yes  No

Estimate the hours the patient needs care on a intermittent basis, if any:

\_\_\_\_\_ hour(s) per day \_\_\_\_\_ days per week from: \_\_\_\_\_ through: \_\_\_\_\_

Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?  Yes  No

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: \_\_\_\_\_ time(s) per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hour(s) or \_\_\_\_\_ day(s) per episode

Does the patient need care during these flare-ups?  Yes  No

Explain the care needed by the patient, and why such care is medically necessary:

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

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Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_