WEST LINN – WILSONVILLE SCHOOL DISTRICT
22210 SW Stafford Rd. Tualatin, OR 97062

FMLA MEDICAL CERTIFICATION FORM—To be completed by Health Care Provider

Employee Name: _____ Today's Date: _____

Employee's Job Title: _____ Job Description Attached: ☐ Yes ☐ No

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

Relationship of family member for whom employee will provide care: _____

Does the patient's condition for which the employee is taking FMLA leave fit into one of the following categories:

_____Because of the birth of a child;
_____Because of the placement of a child for adoption or foster care;

_____In order to care for a family member with a serious health condition;
_____For a serious health condition which prevents the employee from performing job functions;
_____None of the above.

Other:_____

1. Please 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:

2. Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?

   ☐ Yes ☐ No If yes, please list dates of admission: _____

3. Will the employee/family member be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?

   ☐ Yes ☐ No If yes, please estimate beginning and ending dates for the period of incapacity :_____

   _____

4. State the approximate date the condition commenced and the probable duration of the condition:

5. 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 and recovery time?

   ☐ Yes ☐ No If yes, please provide probable duration: _____

6. 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:

7. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments, actual or estimated dates of treatment, if known, and period required for recovery, if any:

8. 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:

9. 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):

10. If medical leave is required for the employee's absence from work because of the employee's own condition, is the employee unable to perform work of any kind (please review the attached job description)?

11. 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 essential functions the employee is unable to perform:

12. If a 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?

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

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

Signature of Health Care Provider

Printed name of Health Care Provider

Address

Telephone

Type of Practice

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's Signature

Date

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