TRISTAR

CERTIFICATION OF HEALTH CARE PROVIDER - OR
(Family and Medical Leave Act (FMLA) and/or the Oregon Family Leave Act (OFLA)

▲ Indicates that an affirmative answer to this question is *not required* for OFLA or concurrent OFLA & FMLA leave.

* Indicates categories that qualify as OFLA leave *only*.

Employee Name:		Patient's Name: (if different from Employee)
Home Address:		
Home Telephone:	Cell Phone:	Other phone:
Employer Name:	Last Day Worked:	First Day Missed:

Release: I authorize TRISTAR, my employer's leave administrator, to contact my Health Care Provider, and I authorize my Health Care Provider to communicate with TRISTAR, for purposes of clarification and authenticity of this medical certification.
Signature of Employee or Patient: _____**Date:** _____

COMPLETE THE FOLLOWING STEPS:
STEP 1: Complete all of the information above. Sign the release.
STEP 2: Give all pages to your Health Care Provider and instruct them to complete.
After your Health Care Provider has completed and signed the bottom,

- **fax the form to TRISTAR at 562/495-6687**
- **email the form to ICSFax@tristargroup.net**
- **mail the form to TRISTAR, 2835 Temple Avenue, Signal Hill, CA 90755.**

TRISTAR only needs one copy of this form, so please choose one method of delivery only.

INSTRUCTIONS to the EMPLOYEE: FMLA/OFLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA/OFLA leave due to your own or your covered family member's serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA/OFLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in delay or denial of FMLA protection. 29 C.F.R. § 825.313. Your employer must give you 15 calendar days to return this form. 29 C.F.R. § 825.305(b), OAR 839-009-0260(4).

Employee Name: _____

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

If patient is a child, date of birth (mm/dd/yyyy): _____/_____/_____

Patient's Relationship to Employee (if employee is not the patient):

- ☐ Spouse, *or* ☐ (**OFLA only*) Same-gender Domestic Partner
- ☐ Parent, *or* ☐ (**OFLA only*) Parent-in-law, *or* ☐ (**OFLA only*) Parent of employee's same-gender Domestic Partner
- ☐ Child, *or* ☐ (**OFLA only*) Child of employee's same-gender Domestic Partner
- ☐ Employee is currently *in loco parentis* (see definition below) to patient who is under age 18 or incapable of self-care due to disability. (Employee has financial or day-to-day responsibility for care of the patient – covered by OFLA and FMLA)
- ☐ (**OFLA only*) Employee was *in loco parentis* to patient. (Employee had financial or day-to-day responsibility for care of the patient when the patient was under 18 – OFLA only)
- ☐ Patient was *in loco parentis* to employee (Patient had financial or day-to-day responsibility for care of the employee when employee was under 18)
- ☐ Grandparent *(*OFLA only)*
- ☐ Grandchild *(*OFLA only)*

"*In loco parentis*" means in the place of a parent, having financial or day-to-day responsibility for the care of a child. A legal or biological relationship is not required.

☐ *(*OFLA only)* Check here if requesting "Sick Child Leave", which is available under OFLA for a child's non-serious health condition. (Completion of this form is only necessary *after* a 3rd occurrence of using Sick Child Leave during a "leave year".)

Employee Name: _____ Employer: _____

INSTRUCTIONS to the HEALTH CARE PROVIDER: Either your patient has requested leave under the FMLA/OFLA or the employee listed above has requested leave under the FMLA/OFLA to care for your patient. 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/OFLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the last page and return all four (4) pages to TRISTAR as instructed above.

Name of Health Care Provider: _____

Address of Health Care Provider: _____

Type of Practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

Note: *If* this form is being used for the purposes of filing for the certification of OFLA' s *non*-serious health condition of a child, only complete # 1*.

1) Approximate date condition commenced: _____
   a. Probable duration of condition: _____
   b. Was the patient admitted for inpatient care in a hospital, hospice, or residential medical care facility?
      ☐ No ☐ Yes. If so, dates of admission: _____
   c. Date(s) you treated the patient for condition: _____
   d. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes
   e. Will the patient need to have treatment visits at least twice per year due to the condition? ☐No ☐ Yes
   f. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
      ☐ No ☐ Yes. If "yes", state the nature of such treatments and expected duration of treatment:
      _____
      _____
2) Is the medical condition pregnancy? ☐ No ☐ Yes. If "yes", expected delivery date: _____
3) If patient is EMPLOYEE: 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.
   a. Is the employee unable to perform any of his/her job functions due to the condition?
      ☐ No ☐ Yes
      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 patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
   _____
   _____

Employee Name: _____ Employer: _____

PART B: AMOUNT OF CARE 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:

5) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes

   If "yes", estimate the beginning and end dates for any period of incapacity: _____

   If this certification relates to the employee's seriously ill family member(s), also complete the following:

   a. Does the patient require assistance for basic medical or personal needs or safety, or for transportation? ☐ No ☐ Yes

   b. Would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? ☐ No ☐ Yes

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

   Please explain the care needed by the patient:

   _____

   _____

   ▲ Affirmative answer to the following question is not required for *OFLA* or concurrent OFLA/FMLA leave.

   Is this care medically necessary? ☐ No ☐ Yes

6) Will the patient require follow-up treatments, including any time for recovery? ☐ No ☐ Yes

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

   _____

   _____

   ▲ Affirmative answer to the following question is not required for *OFLA* or concurrent OFLA/FMLA leave.

   Is this care medically necessary? ☐ No ☐ Yes

7) Will it be necessary for the employee to take leave only intermittently or to work on a less than full-time schedule basis because of the condition or treatment? ☐ No ☐ Yes

   If "yes", expected duration: _____

   Frequency (Check One):

   ☐ One (1) to two (2) days per month

   ☐ Two (2) to three (3) days per month

   ☐ Three (3) to four (4) days per month

   ☐ Other - Explain: _____

   Please explain how employee will use leave intermittently, being as specific as possible including frequency and duration of absences: _____

Employee Name: _____ Employer: _____

8) Will the patient require a regimen of treatment? ☐ No ☐ Yes

If "yes", describe the nature of the treatments: _____

_____

Estimated number of treatments: _____

Estimated interval between treatments: _____

Estimated or actual dates of treatments: _____

What is the duration (and any period required for recovery) for a treatment?

_____

▲ Affirmative answer to the following question is not required for *OFLA* or concurrent OFLA/FMLA leave.

Is this care medically necessary? ☐ No ☐ Yes

▲ Affirmative answer to the following question is not required for *OFLA* or concurrent OFLA/FMLA leave.

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

▲ If "yes", is it medically necessary for employee to be absent from work during the flare ups?

☐ No ☐ Yes If "yes", please explain: _____

Affirmative answer not required for OFLA or concurrent leave

_____

▲ Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of 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)

Affirmative answer not required for OFLA or concurrent leave

Duration: _____ hours or _____ day(s) per episode

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**