TRISTAR

CERTIFICATION OF HEALTH CARE PROVIDER – OR (Oregon and Federal Family and Medical Leave)

Employee Name:			Patient's name: (if different from employee)
Street Address:			
City:	State:	Zip:	Telephone:
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: Complete the upper portion of page 2.
STEP 4: Give all three pages (1, 2 & 3) to your Health Care Provider and instruct them to complete. After your Health Care Provider has completed both pages 1 & 2 and signed the bottom of page 2,

- **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 HEALTH CARE PROVIDER: *Complete both page 1 & 2 and return to your patient or to TRISTAR directly as instructed above.*

Information sought on this form relates only to the condition for which the employee is taking leave.

1. On Page 3 is a description of various health condition categories that qualify for leave under Family and Medical Leave Acts. Please check the appropriate category or categories:

☐ 1-Hospital care ☐ 3-Pregnancy and/or prenatal care ☐ 5-Perm/long-term condition requiring supervision
☐ 2-incapacity plus treatment ☐ 4-Chronic condition requiring treatment ☐ 6-Multiple treatments (non-chronic condition)
☐ 7-Sick child leave (serious and non-serious health conditions)

2. Provide a description of the medical facts that support your certification and explain how they meet the criteria of the category:

_____

_____

_____

3. Approximate date condition began and probable duration: from ___/___/___ through ___/___/___

4. Probable duration of patient's present incapacity (if different): from ___/___/___ through ___/___/___

5. If this is a chronic condition or pregnancy, is the patient presently incapacitated (see Page 3 for definition)?

☐ Yes ☐ No If yes, please provide the duration and frequency of episodes of incapacity:

_____

_____

Employee Name: _____ Employer: _____

6. Will it be necessary for the employee to take:

Full-time leave ☐ Yes ☐ No If yes, from ___/___/___ to ___/___/___

Intermittent leave or work on a less than full-time schedule ☐ Yes ☐ No If yes, from ___/___/___ to ___/___/___

Frequency: ☐ One to two days per month ☐ Two to three days per month ☐ Three to four days per month

☐ Other: Please explain how the employee will use leave intermittently or work a less than full-time schedule, being as specific as possible regarding frequency and duration of absences:

_____

7. If the patient requires a regimen of treatment, what is the nature of and description of the treatments, estimated number of treatments, and intervals between treatments (see Page 3 for definition)?

_____

What are the actual or estimated dates of visits for treatment, or frequency of visits for treatment?

_____

What is the duration of each treatment and any period required for recovery?

_____

8. If this certification relates to the employee's need to care for a family member, complete the following:

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

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

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: _____

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Name of Health Care Provider: _____

Address of Health Care Provider: _____

Office Phone: _____Office Fax: _____

Type of Practice: _____

Signature of Health Care Provider: _____Date: _____

Definitions of Covered Health Conditions:

An illness, impairment, physical or mental condition that involves one of the following:

1. Hospital care –
Inpatient care (i.e., overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Incapacity plus treatment –
A period of incapacity of more than three consecutive calendar days (including any period of incapacity or subsequent treatment relating to the same condition), that also involves:

(a) Treatments two or more times by a licensed healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider, ***or***

(b) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under supervision of the healthcare provider.

(1) Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment DOES NOT include routine physical, dental, or eye examinations.

(2) 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 such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or any other similar activities that can be initiated without a visit to a healthcare provider.

3. Pregnancy –
Any period of incapacity due to pregnancy, pregnancy-related illness, or for prenatal care.

4. Chronic conditions requiring treatments –
A chronic serious health condition is one which:

(a) Requires periodic visits for treatment by a healthcare provider, nurse, or physician's assistant under direct supervision of a healthcare provider;

(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(c) May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/ long-term conditions requiring supervision –
A period of incapacity that 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 healthcare provider. Examples include Alzheimer's, a severe stroke or the terminal states of a disease.

6. Multiple treatments (non-chronic conditions) –
Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either of 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 calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, **etc.), severe arthritis (physical therapy), kidney disease (dialysis).**

7. Sick Child Leave –
An illness, injury or condition (serious and non-serious health condition) of the employee's child requiring home care.

Definition of "Incapacitated": Inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

Directions regarding "Regimen of treatment" (question 5): If the patient is under your supervision, provide a general description of such regimen, such as prescription drugs or physical therapy requiring special equipment. If the treatments will be provided by another provider of health services, such as a physical therapist, please state the nature of the treatments.