

**STATE OF OHIO
PHYSICIAN OR HEALTH CARE PROVIDER CERTIFICATION
FOR THE FAMILY & MEDICAL LEAVE ACT**

CONFIDENTIAL
(Please Print or Type)

Employee's Name (First/Middle/Last)		Social Security Number	
Employee's Job Title:			
Address:	City:	State:	Zip:
Telephone (W) ()	Telephone (H) ()	Agency & Employee Location	
Patient's Name (if different from employee):		Relationship to Employee:	

1) This information is being provided by:

- a) Physician YES NO
- b) Practitioner YES NO
- c) Another provider of health services YES NO

2) Medical facts or other information which would support your certification, and allow the Employer to make a prudent decision in this matter: _____

3) Date condition commenced: ____/____/____ 4) Probable duration of condition: _____

5) Is this a chronic condition? YES NO Explain as necessary: _____

6) When the condition is present, does it prevent the employee from performing the essential functions of the employee's position? YES NO

Please explain: _____

- a) Is this response based upon a review of the employee's written position description? YES NO
- b) Is this response based solely upon the employee's description of his/her duties? YES NO

7) Regimen of prescribed treatment. Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services (OR ATTACH THE REGIMEN OF PRESCRIBED TREATMENT TO THIS FORM): _____

8) If it is necessary for the employee to be off work on an intermittent basis, or to work less than the employee's normal schedule of hours per day or days per week, include schedule of visits or treatment: _____

Hospital Care, complete Section I. Absence plus Treatment, complete Section II. Chronic Condition, complete Section III.	Permanent/Long-Term, complete Section IV. Pregnancy Related, complete Section V. Care of Family Member, complete Section VI.
UPON COMPLETION OF SECTION RELATED TO MEDICAL CONDITION, PLEASE COMPLETE AND SIGN SECTIONS VII & VIII.	

SECTION I—Hospital Care
1) Does this condition require inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity of subsequent treatment in connection with or consequent to such inpatient care? <input type="checkbox"/> YES <input type="checkbox"/> NO
Date(s) of Confinement: IN ____/____/____ OUT ____/____/____

SECTION II—Absence Plus Treatment*				
A period of incapacity of <u>more than 3 consecutive calendar days</u> , or would result in such if left untreated, including any subsequent treatment or period of incapacity relating to the same condition that also involves the following:				
<table style="width: 100%;"> <tr> <td style="width: 15%; vertical-align: top;"> <input type="checkbox"/> YES <input type="checkbox"/> NO </td> <td> 1) Will the individual require <u>treatment two or more times</u> by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care service (e.g., physical therapist) under orders of, or on referral by a health care provider; OR </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> YES <input type="checkbox"/> NO </td> <td> 2) Will the individual require <u>treatment</u> by a health care provider on <u>at least one occasion</u> which results in a <u>regimen of continuing treatment</u> under the supervision of the health care provider? </td> </tr> </table>	<input type="checkbox"/> YES <input type="checkbox"/> NO	1) Will the individual require <u>treatment two or more times</u> by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care service (e.g., physical therapist) under orders of, or on referral by a health care provider; OR	<input type="checkbox"/> YES <input type="checkbox"/> NO	2) Will the individual require <u>treatment</u> by a health care provider on <u>at least one occasion</u> which results in a <u>regimen of continuing treatment</u> under the supervision of the health care provider?
<input type="checkbox"/> YES <input type="checkbox"/> NO	1) Will the individual require <u>treatment two or more times</u> by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care service (e.g., physical therapist) under orders of, or on referral by a health care provider; OR			
<input type="checkbox"/> YES <input type="checkbox"/> NO	2) Will the individual require <u>treatment</u> by a health care provider on <u>at least one occasion</u> which results in a <u>regimen of continuing treatment</u> under the supervision of the health care provider?			
<p>*NOTE: 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 bedrest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.</p>				

SECTION III—Chronic Conditions Requiring Treatment**

1) Does this condition:

- YES NO require periodic visits for treatment by a health care provider, or by nurse or physician's assistant under direct supervision of a health care provider;
- YES NO continue over an extended period of time (including episodes of a single underlying condition); and
- YES NO may possible cause episodic rather than continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

2) Please state whether the patient is presently incapacitated*** and the likely duration and frequency of episodes of incapacity: _____

Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does **not include routine physical examinations, eye examinations, or dental examinations.

***Incapacity, for the purpose of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof, or recovery therefrom.

SECTION IV—Permanent/Long-Term Conditions Requiring Supervision

1) Does this condition require a period of incapacity*** which is permanent or long-term due to a condition for which treatment may not be effective? YES NO

(The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by a health care provider. Examples include Alzheimer's, a severe stroke or the terminal stages of a disease.)

2) Does (or will) the patient require assistance for basic medical needs, hygiene needs, nutritional needs, safety or transportation? YES NO

***Incapacity, for the purpose of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof, or recovery therefrom.

SECTION V—Pregnancy Related

Any period of incapacity due to pregnancy, or for prenatal care.

1) If condition is due to pregnancy, what was/is the expected delivery date?

Month: _____ Day: _____ Year: _____

2) Give dates and fully describe any complications prior to delivery:

Section VI—Care of a Family Member

1) After review of the medical condition, is the employee's presence necessary or would it be beneficial for the care of the patient (this may include psychological comfort)? YES NO

2) When Family and Medical Leave is needed to care for a seriously-ill family member, state the care he/she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule (you may attach additional sheets if necessary): _____

3) Estimate the period of time care is needed or the employee's presence is necessary: _____

SECTION VII—Attending Physician(s)/Health Care Provider(s)

Name(s), specialty, address(es), and telephone number(s) of all providers treating this condition:

	Name	Specialty	Address	Telephone
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____

I certify that the information contained in this form is true to the best of my knowledge.

Date:

Attending Physician's/Health Care Provider's Signature:

SECTION VIII—Certification/Authorization

I voluntarily authorize the Employer's Health Care Provider to contact my Health Care Provider for clarification of the information contained in this certification. Initial here:



I certify that the information contained in this form is true to the best of my knowledge and understand my misrepresentation on my part may result in denial of leave and/or discipline.

Date:

Employee's Signature:

ATTENTION SUPERVISORS: Completed form shall be placed in the confidential section of employee personnel file. This form is for official use only. The information contained herein should **not** be shared with other employees except to the extent needed to make appropriate administrative decisions. Failure to maintain confidentiality of the information reported on this form may be grounds for appropriate corrective action.

PHYSICIAN'S NOTE: The Employer will not be responsible for additional billing charges resulting from a review of the employee's written position description to complete the above information.