

STATE OF OHIO  
**Certification of Health Care Provider**  
**For Employee's Serious Health Condition**  
(FAMILY AND MEDICAL LEAVE ACT)

CONFIDENTIAL  
(Please Print or Type)

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**SECTION I: For Completion by the AGENCY**

**Instructions:** Please complete Section I before giving this form to your employee.

Agency Name and Contact: \_\_\_\_\_

Employee's Job Title: \_\_\_\_\_ Regular Work Schedule: \_\_\_\_\_

Employee's Essential Job Functions: \_\_\_\_\_

Check if Job Description is attached: \_\_\_\_\_

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**SECTION II: For Completion by the EMPLOYEE**

**Instructions:** Please complete Section II before giving this form to your medical provider. The State of Ohio requires that you submit a timely, complete and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. You have 15 calendar days to return this form to your agency.

Your Name (First/Middle/Last): \_\_\_\_\_ OAKS User ID: \_\_\_\_\_

Telephone (W): \_\_\_\_\_ Telephone (H): \_\_\_\_\_

Address: \_\_\_\_\_

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**Certification/Authorization:**

I voluntarily authorize my agency's health care provider, human resources professional, leave administrator, or a management official to contact my health care provider for clarification and authentication of the information contained in this certification. I understand that I may choose not to allow my agency to clarify or authenticate my certification with my health care provider, and that my agency may deny the taking of FMLA if my certification is unclear. 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: \_\_\_\_\_

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**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**Instructions:** Your patient has requested leave under the FMLA. 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 coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Type of Practice/Medical Specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**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?

\_\_\_ No \_\_\_ Yes. If so, dates 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? \_\_\_ No \_\_\_ Yes

Was medication, other than over-the-counter medication, prescribed? \_\_\_ No \_\_\_ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? \_\_\_ No \_\_\_ Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_

2) Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes. If so, expected delivery date: \_\_\_\_\_

3) 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 functions.

Is the employee unable to perform any of his/her job functions due to the condition? \_\_\_ No \_\_\_ Yes.

If so, identify the job functions the employee is unable to perform:

\_\_\_\_\_



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Additional information. Identify question number with your additional answer.

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Signature of Health Care Provider

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Date

**ATTENTION SUPERVISORS:** Completed form shall be placed in the confidential section of the employee's 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.