

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

CONFIDENTIAL
(Please Print or Type)

SECTION I: For Completion by the AGENCY

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

Agency Name and Contact: _____

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 to care for a covered family member with a 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: _____

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

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: _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

Instructions: The employee listed above has requested leave under the FMLA 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 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) Describe other relevant medical facts, if any, related to the condition for which the patient seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE 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.

- 4) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recover? No Yes.

If so, estimate the beginning and end dates for the period of incapacity: _____

During this time, will the patient need care? No Yes.

Explain the care needed by the patient and why such care is medically necessary: _____

- 5) Will the patient need to attend 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:

Explain the care needed by the patient, and why such care is medically necessary: _____

- 6) Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? No Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary: _____

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

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., one episode every three months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

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

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

Explain the care needed by the patient, and why such care is medically necessary: _____

Additional information. Identify question number with your additional answer.

Signature of Health Care Provider

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.