

STATE OF OHIO
PHYSICIAN OR HEALTH CARE PROVIDER CERTIFICATION
FOR OVERNIGHT HOSPITALIZATION
(Please Print)

Employee's Name (First/Middle/Last)		Social Security Number	
Employee's Job Title		Agency & Employee Location	
Home Address	Street	City/State	Zip
Telephone Home/Work ()	()		

1. This information is being provided by:

- a) Physician Yes No
- b) Practitioner Yes No
- c) Another provider of health services Yes No.

Name, title

Phone Number

2. Person hospitalized:

Name

Relationship to Employee (if applicable)

2. Dates of hospitalization: _____.

3. Hospital:

Facility Name

Street

City/State

Zip

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

Attending Physician's/Health Care Provider's Signature

Date

I voluntarily authorize the State of Ohio to contact my Health Care Provider for the limited purpose of clarifying of the information contained in this certification. Employee's Initials: _____

I certify that the information contained in this form is true to the best of my knowledge and understand any misrepresentation on my part may result in a denial of full payment for sick time and discipline.

Employee's Signature

Date