STATE OF OHIO

PHYSICIAN OR HEALTH CARE PROVIDER CERTIFICATION FOR LIVING ORGAN AND BONE MARROW DONOR LEAVE

(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**.

2. Information of Physician or other health services provider who performed the procedure:
Name Address Street City/State Zip

_____

3. Date the procedure commenced: _____.

4. Where the procedure commenced:
Facility Name Address Street City/State Zip

_____

5. Type of procedure: ☐ Kidney or Liver Donation ☐ Bone Marrow Donation

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

I voluntarily authorize the State of Ohio to contact my Health Care Provider for clarification 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 denial of leave and/or discipline.

_____
Date Employee's Signature