STATE OF OHIO

HOSPITALIZATION OR OUTPATIENT SURGERY CERTIFICATION

(Please Print)

Employee's Name (First/Middle/Last):	**Employee ID:**		
Employee's Job Title:	**Agency:**		
Home Address:	**City:**	**State:**	**Zip:**
Telephone (W): ( )	**Telephone (H):** ( )		

1. This information is being provided by: ☐ Physician ☐ Practitioner ☐ Another provider of health services

____

Name   Title   Phone Number

INSTRUCTIONS: Please complete only one of the two sections that follow.

SECTION I: HOSPITALIZATION

2. Patient Information:

____

(Name)

____

(Relationship to Employee (if applicable))

3. Dates of Hospitalization: ____________________

4. Patient was hospitalized overnight? Yes or No

5. Hospital:______________________________

____

____

(Facility Name/Address)

SECTION II: OUTPATIENT SURGERY

6. Patient Information:

____

(Name)

____

(Relationship to Employee (if applicable))

7. Date of Surgery: ____________________

8. Hospital:______________________________

____

____

____

(Facility Name/Address)

Physician's Certification

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

____

Attending Physician/Heath Care Provider Signature   *Date*

Employee's Authorization and Certification

I voluntarily authorize the State of Ohio to contact my health care provider for the limited purpose of clarifying 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 may subject me to discipline.

____

Employee's Signature   *Date*