

Ohio Department of Treasurer  
**CERTIFICATION OF HEALTH CARE PROVIDER  
 FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION  
 (FAMILY AND MEDICAL LEAVE ACT)**

CONFIDENTIAL  
 (Please Print or Type)

<b>SECTION I: For Completion by the AGENCY</b>			
<i>Instructions: Please complete Section I before giving this form to your employee.</i>			
Agency Name		Contact	
<b>SECTION II: For Completion by the EMPLOYEE</b>			
<i>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.</i>			
Your Name (First/Middle/Last)		Employee ID	
Telephone (Work)		Telephone (Home)	
Address	City	State	Zip Code
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			
Employee Signature			Date

**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

City

State

Zip Code

Type of Practice/Medical Specialty

Telephone

Fax

**PART A: MEDICAL FACTS**

1. Medical Condition

2. 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?

Yes  No. 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?  Yes  No

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

Yes  No If so, state the nature of such treatments and expected duration of treatment:

3. Is the medical condition pregnancy?  Yes  No

If so, expected delivery date:

4. 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.*

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

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

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

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

2. Will the patient need to attend follow-up treatments, including any time for recovery?  Yes       No

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:

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

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:

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

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

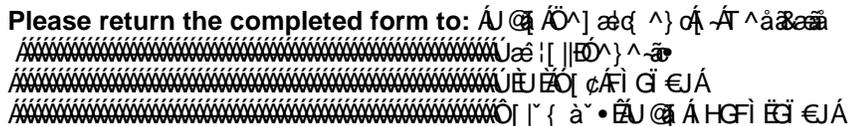
Does the patient need care during these flare-ups?    Yes       No

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

Additional information. Identify question number with your additional answer.

The **Genetic Information Nondiscrimination Act of 2008** (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature of Health Care Provider	Date
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Please return the completed form to: 

**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.