

OSU MEDICAL CERTIFICATION STATEMENT

This form must be completed when requesting Family and Medical Leave on Application for Leave form (#53760). It may also be used for sick leave and medical leave of absence requests. OSU reserves the right to request additional information to verify medical certification. This information is confidential and should not be kept in an employee's personnel file.

Section A To be completed by the employee

Employee's Name _____ Date _____

Patient's Name _____ Family _____
(if different from employee) Relationship _____

General nature of condition:

Section B To be completed by physician/practitioner for employee or family member

1. Will employee/family member be hospitalized? Yes No
2. Description of medical condition and prescribed regimen of treatment:
3. Length of absence or length of time necessary to provide care: (attach schedule of treatments/office visits if leave is to be taken intermittently)
4. Approximate Date of Delivery if maternity related _____

Employee Information

5. Is employee able to perform work of any kind? Yes (complete item 6) No (complete item 7)
6. List any work restrictions:
7. Is medically unable to perform work from _____ through _____

Family Member Information

8. Does/will the patient require assistance for basic medical, hygiene, nutritional, safety or transportation needs? Yes No
9. Is the employee's presence necessary or would it be beneficial for the care of the patient? Yes No

Physician/Practitioner Signature _____ Date _____

Field of Specialization _____

Address _____ Phone _____