

Medical Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave)

SECTION 1: EMPLOYER INFORMATION

Employer Name and Contact

Employee's Job Title

Regular Work Schedule

Employee's Essential Job Functions

Check if job description is attached.

SECTION 2: FOR COMPLETION BY THE EMPLOYEE

Instructions to the Employee: Please complete Section 2 before giving this form to your medical provider. The Family and Medical Leave Act (FMLA) permits an employer to require that you submit timely, complete and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Employee's Full Name: First

M.I.

Last

OSU Employee ID# (required)

SECTION 3: FOR COMPLETION BY THE HEALTH CARE PROVIDER

Instructions to the Health Care Provider: Your patient has requested leave under the FMLA. 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's Name

Business Address: Street

City

State

Zip

Type of Practice/Medical Specialty

Phone Number

Fax

PART A: MEDICAL FACTS

1. Description of Medical Condition:

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?

No Yes If yes, dates of admission: _____

PART A: MEDICAL FACTS CONTINUED

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? No YesWas medication, other than over-the-counter medication, prescribed? No YesWas the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? No YesIf yes, state the nature of such treatments and expected duration of treatment:

_____**2. Is the medical condition pregnancy?** No Yes If yes, expected delivery date: _____**3. Use the information provided by the employer in Section 1 to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.**Is the employee unable to perform any of his/her job functions due to the condition: No YesIf yes, identify the job functions the employee is unable to perform: _____
_____**4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (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****5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?** No Yes

If yes, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No YesIf yes, are the treatments or the reduced number of hours of work medically necessary? No YesEstimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

Hour(s) per day: _____ Days per week: _____ From: _____ Through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? No YesIs it medically necessary for the employee to be absent from work during the flare-ups? No YesIf yes, explain: _____

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., 1 episode every 3 months, lasting 1–2 days):

Frequency: _____ Times per _____ week(s) _____ month(s)

Duration: _____ Hours or _____ day(s) per episode

SECTION 4: ADDITIONAL INFORMATION

Identify question number with your additional answer.

Signature of Health Care Provider

Date

Keep a copy of this form for your personal records. Direct questions and return form and any required documentation to the assigned FML Administrator listed in Section 1 or to:

**Office of Human Resources
Integrated Absence Management and Vocational Services
Email: hr-leaveadministrator@osu.edu
Phone: (614) 292-3439 (Option 3)
Fax: (614) 292-8844**