THE OHIO STATE UNIVERSITY

Medical Certification of Health Care Provider for Family Member's Serious Health Condition

(Family and Medical Leave)

SECTION 1: EMPLOYER INFORMATION

Employer Name and Contact

SECTION 2: FOR COMPLETION BY THE EMPLOYEE

Instructions to the Employee: Please complete Section 2 before giving this form to your family member or his/her 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 to care for a covered family member with a 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

_ Employee's Full Name: First M.I. Last OSU Employee ID# (required)

Name of family member for whom you will provide care:

Full Name: First M.I. Last

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 3: FOR COMPLETION BY THE HEALTH CARE PROVIDER

Instructions to the Health Care Provider: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. 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

Employee's Full Name: First M.I. Last OSU Employee ID# (required)

PART A: MEDICAL FACTS

1. Description of Medical Condition:

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?

☐ No ☐ Yes If yes, dates of admission: _____

Date(s) you treated the patient for condition: _____

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

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ No ☐ Yes

If 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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (medical facts may include symptoms, diagnosis or any regimen of continuing treatment, such as the use of specialized equipment):

PART B: AMOUNT OF CARE 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:

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

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

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

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

5. Will the patient require follow-up treatments, including any time for recovery? ☐ No ☐ Yes

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:

Employee's Full Name: First M.I. Last OSU Employee ID# (required)

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

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:

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

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

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

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

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