THE OHIO STATE UNIVERSITY

Leave as an Accommodation Medical Certification

This form (or a similar letter that addresses the information requested) must be completed and signed by the treating health care provider when an employee is **not eligible for FMLA leave and needs leave as an accommodation on an intermittent, reduced schedule or continuous basis**. The information provided will be reviewed to determine if non-FMLA leave can be granted. Submission of paperwork does not automatically guarantee approval of leave. **Documentation should be faxed to the Office of Human Resources at 614-688-8120.**

Please note: Ohio State allows employees to work with restrictions (e.g. light duty, modified schedule, etc.) as they gradually progress to full duty.

SECTION 1: COMPLETED BY EMPLOYEE

Employee Name _____ Employee ID _____

Job Title _____ Department _____ Regular Work Schedule _____

Job Duties _____

SECTION 2: COMPLETED BY THE HEALTH CARE PROVIDER

1. Please describe the nature and severity of your patient's medical condition, including relevant medical facts related to the condition (e.g. diagnosis, symptoms, and regimen of treatment) and functional limitations as it relates to their need for leave.

   _____

   _____

2. If your patient requires a **continuous leave** due to incapacitation from performing any work, please list the begin date and end date for the period of incapacitation. **Begin date:** _____ **End Date:** _____

   a. If known, please also provide an estimated return to work date and progression plan to full duty.

   _____

   _____

   b. How confident are you in this return to work plan and date?
   ❑ Very Confident ❑ Moderately Confident ❑ Not Confident

3. If it is necessary for your patient to miss work for **episodic flare-ups**, please list the probable duration and frequency. Consider your patient's medical history and knowledge of the medical condition to provide an estimate.

   FREQUENCY: _____ times per _____ week(s) _____ month(s) **DURATION:** _____ hours or _____ day(s) per episode

4. If it is necessary for your patient to work **reduced hours** on an ongoing basis, how many hours can the patient work?

   _____ **hours/day** _____ **days/week** **Estimated Full Time Return Date:** _____

5. If your patient needs to miss work due to related **medical appointments**, estimate the treatment schedule:

   _____

   _____

Additional Comments: _____

_____

_____

SECTION 3: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name / Practice _____

Phone _____ Fax _____ Signature _____ Date _____