

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

CONFIDENTIAL
(Please Print or Type)

SECTION I: For Completion by the AGENCY <i>Instructions: Please complete Section I before giving this form to your employee.</i>			
Agency Name	Contact		
Employee's Job Title	Work Schedule		
Employee's Essential Job Functions			
Check if Job Description is attached <input type="checkbox"/>			
SECTION II: For Completion by the EMPLOYEE <i>Instructions: Please complete Section II before giving to your medical provider. The State of Ohio requires that you submit a timely, complete and sufficient medical certification to support to a request for FMLA leave due to your own 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 <i>(First/Middle/Last)</i>		Employee ID	
Telephone <i>(Work)</i>		Telephone <i>(Home)</i>	
Address	City	State	Zip Code
Certification/Authorization: I voluntarily authorize my agency's health care provider, human resources professional, leave administrator, or a management official to contact my health care provider for clarification and authentication of the information contained in this certification. I understand that I may choose not to allow my agency to clarify or authenticate my certification with my health care provider, and that my agency may deny the taking of FMLA if my certification is unclear. Initial here <div style="text-align: center; margin: 10px 0;"> <div style="border: 1px solid black; width: 80px; height: 40px; display: inline-block;"></div> </div>			
I certify that the information contained in this form is true to the best of my knowledge and understand my misrepresentation on my part may result in denial of leave and/or discipline.			
Employee's Signature			Date

SECTION III: For Completion by the HEALTH CARE PROVIDER

Instructions: 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. 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. Use the information provided by the employer in Section I 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 functions.

Is the employee unable to perform any of his/her job functions due to the condition? Yes No

If so, identify the job functions the employee is unable to perform:

5. Describe other relevant medical facts, if any, related to the condition for which the employee 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

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recover? Yes No
If so, estimate the beginning and end dates for the period of incapacity:

2. 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? Yes No
If so, are the treatments or the reduced number of hours of work medically necessary? 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: _____

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

_____ hour(s) per day; _____ days per week from _____ through _____

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? Yes No

Is it medically necessary for the employee to be absent from work during the flare-ups? Yes No
If so, 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., one episode every three months lasting 1-2 days):

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

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

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 generic 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: Ohio Department of Medicaid
50 West Town Street, 5th Attn: Payroll
Columbus, Ohio 43215
ATTN: MCD.Payroll_Benefits@medicaid.ohio.gov

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.