

Ohio Department of Medicaid
HOSPITALIZATION OR OUTPATIENT SURGERY CERTIFICATION

(Please Print)

Employee's Name (First, Middle, Last)	Employee ID		
Employee's Job Title	Agency		
Home Address	City	State	Zip
Telephone (W)	Telephone (H)		

1. **This information is being provided by:** Physician Practitioner Another provider of health services
Name Title Phone Number

INSTRUCTIONS: Please complete only one of the two sections that follow.

SECTION I: HOSPITALIZATION

2. **Patient Information**
(Name)

(Relationship to Employee (if applicable))

3. **Dates of Hospitalization**

4. **Patient was hospitalized overnight?**
 Yes or No

5. **Hospital**

(Facility Name/Address)

SECTION II: OUTPATIENT SURGERY

6. **Patient Information**
(Name)

(Relationship to Employee (if applicable))

7. **Date of Surgery**

8. **Hospital**

(Facility Name/Address)

Physician's Certification

I certify that the information contained in this form is true to the best of my knowledge.

Attending Physician's/Health Care Provider's Signature

Date

Employee's Authorization and Certification

I voluntarily authorize the State of Ohio to contact my Health Care Provider for the limited purpose of clarifying of the information contained in this certification. Employee's Initials: _____

I certify that the information contained in this form is true to the best of my knowledge and understand any misrepresentation on my part may result in a denial of full payment for sick time and discipline.

Employee's Signature

Date

