OHIO UNIVERSITY
Human Resources

FMLA: Certification of Physician/ Health Care Provider Employee

To be completed by employee's Physician or Health Care Provider. Please do not include actual medical diagnosis. Job description may be required by physician.

1. Employee's Name: _____

2. The attached sheet describes what is meant by a "**serious health condition**" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.
   (1) ☐ (2)☐ (3)☐ (4)☐ (5)☐ (6)☐ or ☐None of the above _____

3. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:
   _____
   _____
   _____

4. State the approximate **date** the condition commenced: _____
   a) State the probable **duration** of the condition/incapacity._____
      _____
      _____
   b) Will it be necessary for the employee to work only **intermittently or to work on a less than full schedule** as a result of the condition (including treatment described in item 5 below)?_____
      If yes, give the probable duration: _____
      _____
   c) If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2].
      _____
      _____
      _____

5. If additional **treatments** will be required for the condition, provide an estimate of the probable number or such treatments:
   _____
   _____

   If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, please provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recover if any:

   a) If any of these treatments will be provided by **another provider of health services** (e.g. physical therapist), please state the nature of the treatments:

   b) If a **regime of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

[1] Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking Family Medical Leave.
[2] **"Incapacity,"** for purposes of Family Medical Leave, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment, thereof, or recovery therefrom.

6. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform** work of any kind? ☐YES or ☐NO

   a) If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job**?☐ YES or ☐NO

      If yes, please list the essential functions the employee is unable to perform:

      _____
      _____
      _____

   b) If neither a nor b applies, is it necessary for the employee to be **absent from work for treatment**?

      _____
      _____
      _____

Health Care Provider Name: _____ Licensure: _____

Health Care Provider Signature: _____ Date: _____

Address:_____ Phone Number: _____

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that one involves one of the following:

1. **Hospital Care**
   Inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment**
   a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:
      1. **Treatment**[3] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
      2. **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[4] under the supervision of the health care provider.

3. **Pregnancy**
   Any period of incapacity[2] due to **pregnancy**, or for **prenatal care**.

4. **Chronic Conditions Requiring Treatments**
   A **chronic condition** which:
   1. Requires **periodic visits** for treatment by a healthcare provider, or by a nurse or physician's assistant under direct supervision of a health care provider
   2. Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
   3. May cause **episodic** rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. **Permanent/Long-term Conditions Requiring Supervision**
   A period of **incapacity**[2] which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but not be receiving active treatment by, a health care provider** (e.g., Alzheimer's, a severe stroke, or the terminal stages of a disease)

6. **Multiple Treatments (Non-Chronic Conditions)**
   Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either from **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of incapacity**[2] **of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

[3] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[4] A regimen of continuing treatment includes, for example, a course of prescription medication (*e.g.,* an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.