OHIO UNIVERSITY
Human Resources

Medical Certification Statement for the Illness of a Family Member or if taking Caregiver Leave for injury or ill Service Member

To be completed by Physician or Health Care Provider.

Name of employee:_____

Name of ill family member:_____

Date condition began:_____

Date condition ended (or is expected to end): _____

Medical facts regarding the condition:_____

_____

_____

_____

Explanation of extent to which employee is needed to care for the ill family member:

_____

_____

_____

Will it be necessary for the employee to work intermittently or to work on less than a full schedule due to this condition? _____,

If yes, please state the probable duration: _____

If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

_____

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

If the treatments will be provided on an intermittent or part-time basis, provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any: _____

_____

If any of these treatments will be provided by another provider of health services, please state the nature of the treatments: _____

_____.

Does the patient require assistance for basic medical or personal needs or safety, or for transportation?

_____.

If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? _____.

If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need: _____.

Name of Health Care Provider: _____ Licensure: _____

Signature of Health Care Provider: _____ Date: _____

Address: _____ Phone Number: _____