



THE SUPREME COURT of OHIO

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

Instructions: Please complete Section I before giving this form to your employee.

Agency Name and Contact: Supreme Court of Ohio, Office of Human Resources FAX 614-387-9479

Employee's Job Title: Regular Work Schedule: M - F, 8 hours per day

Employee's Essential Job Functions: See attached

Check if Job Description is attached: [X]

SECTION II: For Completion by the EMPLOYEE

Instructions: Please complete Section II before giving this form to your medical provider. The Supreme Court requires that you submit a timely, complete and sufficient medical certification to support 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 delay or denial of your FMLA request. This form must be returned to the Office of Human Resources within 15 days.

Your Name (First/Middle/Last): EmplID:

Telephone (W): Telephone (H):

Address:

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:



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.

Date: Employee's Signature:

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: _____

Type of Practice/Medical Specialty: _____

Telephone: _____ Fax: _____

PART A: MEDICAL FACTS

1) 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?

No Yes. 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? No Yes

Was medication, other than over-the-counter medication, prescribed? No Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? No Yes. If so, state the nature of such treatments and expected duration of treatment:

2) Is the medical condition pregnancy? No Yes. If so, expected delivery date: _____

3) 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? No Yes.

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

Additional information. Identify question number with your additional answer.

Signature of Health Care Provider

Date

GINA DISCLAIMER

The GINA Disclaimer should be provided with all Health Care Certifications given to the physician to complete.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic 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 and individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.