Youngstown STATE UNIVERSITY

CERTIFICATION OF HEALTH CARE PROVIDER
For EMPLOYEE's Serious Health Condition

To apply for a Family and Medical Leave this certification from your health care provider must be completed and returned within 15 days of the request for leave.

To be completed by Employee:

Name (Last, First, Middle):	Department:
Job Title:	Regular work Schedule: _____ hours/day _____ days/week _____ shift
Essential Job Functions:	

A **Serious Health Condition** is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

To be completed by Healthcare Provider:
PART A: MEDICAL FACTS

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:	
Is the medical condition pregnancy? If so, expected delivery date: _____	☐ Yes ☐ No
Based on the job duties noted above, 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:	
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	
Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?	☐ Yes ☐ No
If so, estimate the beginning and ending dates for the period of incapacity: Beginning: _____ Ending: _____	
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 _____	
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., 1 episode every 3 months lasting 1-2 days): Frequency: _____ times per _____ week(s) month(s) _____ Duration: _____ hours or _____ day(s) per episode	
Additional Information:	

SIGNATURE OF HEALTH CARE PROVIDER:_____ DATE: _____

Please print name: _____Type of Practice/Specialty:_____

Address:_____ Phone#:_____Fax #:_____

Return To: Human Resources
Youngstown State University
One University Plaza
Youngstown, OH 44555

Phone: (330) 941-2137
Fax: (330) 941-3258