Youngstown STATE UNIVERSITY

CERTIFICATION OF HEALTH CARE PROVIDER
For FAMILY MEMBER'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:

Employee's Name (Last, First, Middle):	Name of family member for whom you will provide care:
Relationship:	If family member is son or daughter, date of birth: _____/_____/_____
Describe care you will provide to your family member and estimate leave needed to provide care:	

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
Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):	

PART B: AMOUNT OF CARE NEEDED ***When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.***	
Will the patient 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: _____	
During this time, will the patient need care?	☐ Yes ☐ No
Explain the care needed by the patient and why such care is medically necessary:	
Will the patient need to attend follow-up treatments, including any time for recovery?	☐ 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:	
Explain the care needed by the patient and why such care is medically necessary:	
Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?	☐ Yes ☐ No
Estimate the hours the patient needs care on an intermittent basis _____ hour(s) per day; _____ days per week from _____ through _____	
Explain the care needed by the patient and why such care is medically necessary:	
Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?	☐ 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

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Fax: (330) 941-3258