

CERTIFICATION OF HEALTH CARE PROVIDER
 RETURN ORIGINAL TO: University Health Services
 University of Cincinnati, M. L. #0010
 Cincinnati, OH 45267-0010
 Phone: 513-584-4457 Fax: 513-584-2222

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| <p><u>Instructions for Employee</u></p> <ol style="list-style-type: none"> 1. Complete Section 1. 2. Promptly give this form to your health care provider and request that the provider return the form to University Health Services (address above) within 2 weeks. 3. If you have questions, contact the Benefits Office at 513-556-6381. | <p><u>Instructions for Health Care Provider</u></p> <ol style="list-style-type: none"> 1. Complete Section 2. 2. <u>Return to University Health Service (address above) within 2 weeks of receipt. Address and fax number above.</u> 3. If you have questions, contact University Health Services at 513-584-4457. |
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SECTION 1 (TO BE COMPLETED BY EMPLOYEE):

Employee Name: _____ Employee ID/M#: _____

Job Title/Department: _____ Employee Date of Birth: _____

Phone #: (Home) _____ (Work) _____

Patient's Name (if different) _____ Relationship: _____

I hereby authorize the University to contact the health care provider referenced below in order to clarify information contained in this certificate and to confirm the validity of this certificate.

 Signature of Patient or Parent (if minor) Date

SECTION 2 (TO BE COMPLETED BY HEALTH CARE PROVIDER)

1. Patient's Name: _____

2. Does the patient have a "Serious Health Condition," as defined below? Yes No .
 If yes, check the appropriate category below and answer the remaining questions on Page 2.
 If no, answer questions 3 and 4 and sign the form at the bottom of Page 2.

NOTE: Serious Health Condition does NOT include such things as cosmetic surgery, the "common cold", flu, earaches, upset stomach, minor ulcers and headaches other than migraines, unless inpatient care is required or complications arise.

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

- Inpatient Care (i.e., overnight stay).
- Pregnancy/prenatal care (patient must be incapacitated).
- Incapacity* of more than three consecutive days involving two or more treatments by a health care provider or one treatment that results in a regimen of continuing treatment (i.e., prescription medication or physical therapy requiring special equipment).
- Chronic conditions that require periodic treatment and may cause episodic periods of incapacity (e.g., epilepsy).
- Permanent or long term conditions resulting in incapacity and requiring continuing supervision by health care provider (e.g., Alzheimer's, severe stroke).
- Multiple treatments by a health care provider for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days in the absence of medical intervention (e.g., cancer and chemotherapy treatment).

*Incapacity means inability to work, attend school or perform regular daily activities.

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3. Describe the medical facts which support your certification:

4. If the patient is a UC employee, when will the patient be released to return to work?

- without restrictions
 with the following restrictions:

Duration of restrictions _____

5. With regard to the serious health condition of the patient, please state:

- a. Date when condition commenced _____
b. Dates of incapacity _____
c. Probable duration _____
d. Frequency of episodes of incapacity _____
e. Nature of ongoing treatment _____

6. Is it medically necessary for the patient to work only intermittently or on a reduced schedule? Yes No If yes, give the probable duration and describe the applicable restrictions or anticipated schedule of treatments. _____

7. If leave is to care for the employee's family member, is the employee needed to care (medically or psychologically) for the patient? Yes No . If yes, describe the care which the employee will provide: _____

8. If leave is requested to care for the employee's family member, and the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need and the anticipated schedule of such care: _____

Signature of Health Care Provider

Print Name of Health Care Provider

Address

Telephone Number