



**Section I. Employee Completes this Section**

Employee Name: \_\_\_\_\_ Patient's Name: \_\_\_\_\_

Patient's relationship to employee (check one):

- Self       Spouse       Child (age\_\_\_\_)       Parent       Parent-in-law       Grandparent
- Domestic Partner       Child of domestic partner (age\_\_\_\_)       Parent of domestic partner       Grandchild

**Section II. Health Care Provider Completes this Section**

The above employee has requested medical leave. In order to verify the employee's entitlement, please complete and return this form to either the employee or directly to OSU Office of Human Resources. *Note: To comply with the Genetic Information Nondiscrimination Act of 2008 (GINA), we ask that you do not provide any genetic information when responding to this request for medical information.*

**Health Condition**

1. Please indicate all categories applicable to the patient's health condition (descriptions are provided on page two):

- Requires overnight hospital care, hospice, or treatment at a residential care facility
- Requires absence from work (of more than three consecutive days) plus treatment
- Pregnancy disability or prenatal care       Permanent or long-term condition requiring supervision
- Chronic condition requiring treatment       Requires multiple treatments for a non-chronic condition
- None of the above

- 2. Date the condition commenced: \_\_\_\_\_
- 3. Dates you treated the patient for the condition: \_\_\_\_\_
- 4. Probable Duration of Condition: (from) \_\_\_\_\_ (to) \_\_\_\_\_
- 5. Relevant medical facts: \_\_\_\_\_

**Medical Leave Requirements**

- 1. If the patient is the employee, is the employee able to perform his/her job with the condition?
  - Can perform all functions all the time
  - Can perform all functions most of the time, but will have intermittent periods of incapacity
  - Cannot perform the following functions: \_\_\_\_\_
- 2. If the patient is not the employee, is the employee's presence required to assist the patient in basic medical or personal needs, for safety or for transportation?     Yes     No     N/A, patient is employee  
 Would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery?     Yes     No
- 3. Is it medically necessary for the employee to be off work in order to assist a family member or to receive their own **treatment(s)** for a serious health condition?     Yes     No

*If yes, please describe:*

Continuous Leave    from \_\_\_\_\_ to \_\_\_\_\_

Intermittent Leave    from \_\_\_\_\_ to \_\_\_\_\_

Number of hours per day/days per week, etc. the employee needs to be away from work for treatments/recovery

Reduced Schedule    from \_\_\_\_\_ to \_\_\_\_\_

Number of hours per day/days per week, etc. the employee may work

- 4. If the condition is a chronic condition, is it medically necessary for the employee to be off work periodically to care for a family member or for their own episodic flare-ups of the condition?     Yes     No     N/A, not chronic condition

*If yes, please describe the likely frequency and duration of episodes of incapacity:*

\_\_\_\_\_

**I certify that the information provided by me is true and accurate.**

Signature of Health Care Provider \_\_\_\_\_

Date \_\_\_\_\_

Print Name of Health Care Provider \_\_\_\_\_

Provider's Field of Practice \_\_\_\_\_

Provider's Address \_\_\_\_\_

Provider's Telephone Number \_\_\_\_\_

## Family & Medical Leave Definitions

For purposes of leave under the Family & Medical Leave Act (FMLA), a **serious health condition** means an illness, injury, impairment, or physical or mental condition that involves **one** of the following:

*Note: Incapacity for purposes of FMLA and OFLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.*

1. **Inpatient Care:** An overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.
2. **Absence Plus Treatment:** A period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
  - a. **Treatment two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapist) under orders of, or on referral by, a health care provider; or
  - b. **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** under the supervision of the health care provider.

Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye or dental examinations.

A regimen of continuing treatment includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the use of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

3. **Pregnancy:** Any period of incapacity due to pregnancy or for prenatal care.
4. **Chronic Conditions Requiring Treatments:** A chronic condition is one which:
  - a) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
  - b) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
  - c) May cause **episodic** rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.).
5. **Permanent/Long Term Conditions Requiring Supervision:** A period of **incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be under the **continuing supervision of, but does not need to be receiving active treatment by, a health care provider.** (e.g. Alzheimer's, severe stroke, or terminal stages of a disease)
6. **Multiple Treatments (Non-Chronic Conditions):** Any period of absence to receive **multiple treatments** (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for:
  - a) **Restorative surgery** after an accident or other injury; or
  - b) A condition that would likely result in a **period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).