Return To:
Office of Human Resources
1851 North Research Drive
Bowling Green, OH 43403
Fax:419-372-2920

Certification for Leave

1. Employee's Name

Last First M.I.

2. BGSU ID Number

3. Title

4. Employee Type

◯ Classified ◯ Administrative ◯ Faculty

5. Department

Name

6. Preferred Contact Address and Contact Number

Address Phone Number

7. Request Is For:

◯ BGSU Employee (Self) ◯ Legal Spouse/Dependent

8. Proof of Relationship Status

◯ I have provided legal evidence of relationship status (e.g. birth certificate or other court documentation)

9. Name of Legal Spouse/Dependent (if applicable)

Last First M.I.

10. Relationship of Family member to you (if applicable)

Relationship ______ Date of Birth ______

11. Additional Job Functions for BGSU Employee, if request is for the BGSU Employee only (Please obtain and attach essential job functions from the Office of Human Resources)

☐ Check if job description is attached

Regular Work Schedule ______

12. Employee Authorization

I hereby authorize the undersigned physician to release any and all information from the examination report and other pertinent facts concerning Serious Illness or injury for myself or immediate family member to the Leave Bank Committee and agree to hold them harmless for the use of said report. I understand that this report will only be used in accordance with the Leave Bank Policy, HIPPA , and Bowling Green State University Policies.

Signature Date

--- Please Keep a Copy For Your Records ---

Leave Bank Physicians Certification

13. Medical Information- To be Filled out by the Health Care Provider

State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity** if different):

Date Condition Commenced ______________ Probable Duration of Condition ______________________________

Question	No	Yes
Does the condition require the patient to be incapacitated or treated connected with inpatient care (e.g. overnight stay) in a hospital, hospice, or residential medical care facility?	☐ No	☐ Yes
Does the condition require the patient's absence from work for ten (10) or more consecutive working days and that involves continuing treatment by (or under the supervision of) a licensed health care provider?	☐ No	☐ Yes
Does the condition require the patient to be incapacitated due to a chronic serious health condition (e.g. asthma, diabetes, epilepsy, etc.)?	☐ No	☐ Yes
Does the condition require the patient to be incapacitated long term for treatment which may be ineffective (e.g. stroke, terminal disease, etc.)?	☐ No	☐ Yes
Does the condition require the patient to be absent from work to receive multiple treatments (including any period of recovery there from) either from restorative surgery after an accident or other injury, or for a chronic condition such as cancer or kidney disease?	☐ No	☐ Yes

14. Relevant Medical Facts- Describe other relevant medical facts related to condition above for which the patient requests leave. These should include symptoms, diagnosis, regimen of continuing treatment, use of specialized equipment, prognosis, etc.

(Please attach additional documentation, as needed)

15. Physician Certification

I hereby certify that the medical information in regards to the patient listed above is accurate.

Signature ______________ Date ______________ Signed By ______________ Title ______________

Phone Number **Type of Practice**

Office Address