

**OHIO DEPARTMENT OF NATURAL RESOURCES
APPLICATION TO REQUEST DONATED LEAVE**

Physician or Practitioner Statement

PROVIDE INFORMATION APPLICABLE TO THE EMPLOYEE OR FAMILY MEMBER

Medical Certification

This information is being provided by:

- a. Physician
- b. Practitioner
- c. Other Provider of Health Services

Medical facts or other information regarding the serious illness/injury. (PLEASE BE SPECIFIC)

Date the illness commenced: _____

Probable duration of the illness: _____

Is this a chronic illness? Yes No

Explain as necessary _____

Describe the treatment schedule and anticipated completion date:

How will the employee's presence be beneficial for the care of the family member and what is the estimated time period the employee's presence is necessary: _____

Name of Practice: _____
Address: _____

Phone: _____
Fax: _____

Physician or Practitioner Signature

Date