Oklahoma Department of Corrections
Standard FMLA/Shared Leave Medical Certification Form

To the Employee: Please complete this section of the form, provide to the Health Care Provider, and, when completed, return to your facility/district/unit.

Employee's Name: _____ Patient's Name:_____
(if different from employee)

Relationship of Patient (if different from employee) to Employee: _____

I hereby authorize the Department of Corrections' health care provider to contact the health care provider listed solely for the purpose of clarifying or authenticating the information contained herein, if necessary.

_____ _____
Employee's Signature Date

To the Health Care Provider: Please complete this section of the form and return to the employee:

1. **Listed below are the categories of a <u>serious health condition</u> (illness, injury impairment, or physical or mental condition) under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described?** ☐ Yes ☐ No If yes, please check the applicable category under which the patient's condition qualifies:

☐ **Hospital Care:** Inpatient care (an overnight stay) in a hospital, hospice, or residential facility including any period of incapacity* or subsequent treatment in connection with such care

☐ **Absence Plus Treatment:** Incapacity of more than **three consecutive calendar days** that also involves:

- Treatment two or more times by a health care provider, nurse or physician's assistant under the direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapist) under the orders of, or on referral by, a health care provider

Or

- 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

☐ **Pregnancy:** Any period of incapacity due to pregnancy or for prenatal care

☐ **Chronic Conditions Requiring Treatment:** A chronic condition that:

- Requires periodic visits for treatment by a health care provider, nurse or physician's assistant under the direct supervision of a health care provider;
- Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- May cause episodic rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.)

☐ **Permanent/Long-term Conditions Requiring Supervision:** A period of incapacity that 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 need not be receiving active treatment by, a health care provider (e.g. Alzheimer's, severe stroke, or the terminal stages of a disease)

☐ **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 restorative surgery after an accident or other injury, or for 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), and kidney disease (dialysis).

***"Incapacity** is defined to mean inability to work or perform other regular daily activities due to the serious health condition, treatment therefore or recovery therefrom."

2. **Describe the serious health condition:**

   a. Identify the **medical facts** that support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories: _____
   _____
   b. State the approximate date the condition commenced: _____ ; the probable duration of the condition: _____; the probable duration of the patient's present incapacity (if different): _____
   c. If the condition is **chronic** or **pregnancy**, is the patient is presently incapacitated? ☐ Yes ☐ No. What is the likely duration and frequency of **episodes of incapacity?** _____
   d. Does the employee have a condition that is likely to result in death within 2 calendar years? ☐ Yes ☐ No

3. **Additional treatment(s) for the serious health condition, if any:**

   a. Provide an estimate of the probable number of such treatments: _____
   b. If any of these treatments will be provided by another provider of health services (e.g. physical therapist), please state the nature of such treatments: _____
   c. If a regimen of continuing treatment is required under your supervision, provide a general description of such regimen (e.g. prescription drugs, physical therapy requiring special equipment): _____

4. **Employee's ability to work/absence from work:**

   a. If medical leave is required for the employee's absence from work because of the employee's own condition, is the employee unable to perform work of any kind? ☐ Yes ☐ No
   b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? ☐ Yes ☐ No
   If yes, please list the essential functions the employee is unable to perform: _____
   _____
   c. If neither of the above, is it necessary for the employee to be absent from work for treatment? ☐ Yes ☐ No

5. **Complete this section if leave is required to care for a family member with a serious health condition:**

   a. Does the family member require assistance for basic medical or personal needs, safety, or for transportation? ☐ Yes ☐ No
   b. If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery? ☐ Yes ☐ No

6. **Complete this section if the employee requires intermittent leave or a reduced work schedule:**

   a. If the employee must be absent intermittently or work a reduced schedule as a result of his/her serious health condition, state the probable duration: _____ and/or describe the reduced work schedule needed:_____
   b. If the intermittent absence or reduced work schedule is required due to treatment for the serious health condition, please provide: an estimate of the probable number of treatments _____
      the interval between treatments _____
      actual or estimated dates of treatment _____
      period required for recovery, if any _____
   c. If a family member will need care only intermittently or on a part-time basis, what is the duration of this need?_____

7. **Health Care Provider Information:**

   Name (printed): _____Signature:_____
   Address: _____
   Telephone #:_____ Type of Practice: _____ Date:_____

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