Oklahoma City Public Schools

Certification of Healthcare Provider for Employee's Serious Health Condition (Non FMLA Eligible)

PURPOSE: For employees on medical leave who did not qualify for, or have exhausted, Family and Medical Leave allotment. The named employee has requested a medical leave of absence. This form will provide OKCPS with information needed to determine how long and what type of leave the employee will need.

INSTRUCTIONS:

HEALTH CARE PROVIDER: **Please DO NOT disclose the employee's underlying diagnosis.** Your patient (our employee) has requested leave for their serious health condition. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the employee. Be as specific as possible; terms such as "indefinite," "unknown," or "indeterminate" *are not sufficient* to determine leave coverage. Limit your responses to the condition for which the employee is seeking medical leave. Be sure to sign and date the form.

EMPLOYEE: Submit timely, complete, and sufficient medical documentation to support your request. Failure to provide a complete and sufficient medical certification to OKCPS may result in a delay or denial of your requested leave.

Please complete form and have the employee return it, or fax it to the OKCPS Benefits Department.

SECTION I: To be completed by Employee's DEPARTMENT REPRESENTATIVE

EMPLOYEE'S NAME		EMPLOYEE'S JOB TITLE
TELEPHONE **405.587.0801**	FAX **405.587.0148**	E-MAIL Leave@okcps.org

SECTION II – To be completed by HEALTH CARE PROVIDER

PART A: MEDICAL FACTS*

(1) Probable DURATION of condition: **From:**_____ **To:** _____

(2) Does the employee have a serious health condition? If yes, provide a brief description below. ☐ Yes ☐ No

PART B: AMOUNT OF LEAVE NEEDED

(3) Is it necessary that the employee be on leave for a single continuous period of time due to his/her medical condition, including time for treatment and recovery? ☐ Yes ☐ No

If **yes**, estimate the dates for the period of incapacity: **From:**_____ **To:**_____

PART C: INTERMITTENT LEAVE – Complete only if leave is on an ***intermittent basis*** or a ***reduced schedule***.

(4) Will the medical condition cause **episodic flare-ups** that make it medically necessary to leave work **intermittently** or work a **reduced schedule**? ☐ Yes ☐ No

a) Reduced schedule: Work no more than: _____ Hours/Day _____ Days/Week
From: _____ To: _____

b) Intermittent leave: Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hours or _____ day(s) per episode

SECTION III: INFORMATION & SIGNATURE OF HEALTH CARE PROVIDER

PROVIDER'S NAME	ADDRESS OR STAMP
TELEPHONE	FAX
SIGNATURE OF HEALTH CARE PROVIDER	DATE

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.