Oklahoma Department of Corrections
Health Care Provider Statement

To the Health Care Provider:

The referenced patient has requested approval to cover an absence from work with sick leave or other approved leave program that may be substituted for sick leave. The Oklahoma State Merit Rules for Employment permit such leave usage only "**when the employee cannot work because of sickness, injury, pregnancy, or medical, surgical, dental or optical examination, or treatment, or where the employee's presence at work would jeopardize the health of the employee or others."**

Please complete this form and provide to the employee to return to his/her supervisor. Upon receipt of the information provided, a decision will be made whether to approve the employee's request for leave.

Part A: Name of Patient: _____
Name of Health Care Provider: _____
Provider's Address: _____
_____
Provider's Telephone #: _____

Part B: ___ Yes or ___ No For the date(s) specified below, the patient was unable to work due to sickness, injury, pregnancy, medical/surgical/dental/optical examination or treatment, or because the employee's presence at work would jeopardize the health of the employee or others.

Date(s) unable to work: From _____ To _____ and/or on the following appointment dates and times:
_____
Date/time Date/time Date/time Date/time Date/time

Part C: ___ Yes or ___ No This absence was medically necessary and consistent with the serious health condition previously certified by your office as requiring intermittent family and medical leave (FMLA).

I certify that the above information is true and correct.

_____ _____
Signature of Health Care Provider Date

(R 2/06)

Distribution: To Personnel File