Oklahoma Department of Corrections
Military Family (NDAA) Medical Certification Form

To the Employee: Please complete this section of the form, provide to the Health Care Provider of your covered service member and, when completed, return it to your facility/unit personnel officer.

Employee's Name: _____ State Employee ID #_____

Covered Service member's Name:_____

Relationship of Covered Service member 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. **Is the covered service member, listed above, recovering from a serious illness or injury sustained in the line of duty on active duty?**
   Yes No

2. **Describe the serious illness or injury sustained in the line of duty on active duty:**
   a. Identify the **medical facts** that support your certification: _____
   _____
   _____
   _____
   b. State the approximate date the condition commenced: _____
   c. State the probable duration of the condition: _____

3. **Complete this section to certify that care for the covered service member is required from their spouse, parent, son, daughter, or next of kin, who is currently an employee of the Oklahoma Department of Corrections and has requested the use of military family leave as provided for by the National Defense Authorization Act of 2008 (NDAA), Section 585(a):**
   a. Does the service 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 service member's recovery?
      Yes No

4. **Complete this section if the covered service member's caregiver, our employee requesting military family leave (MFMLA), requires intermittent leave or a reduced work schedule:**
   a. The service member will only need care from our requesting employee intermittently.
   What is the duration of this need? _____
   b. The service member will only need care from our requesting employee on a part-time basis.
   What is the duration of this need?_____

5. **Health Care Provider Information:**

Name (printed): _____

Signature:_____ Date:_____

Address: _____

Telephone #:_____ Type of Practice: _____

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