CERTIFICATION OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S PREGNANCY, PRENATAL MEDICAL CARE, CHILD BIRTH, CARE FOR A CHILD AFTER BIRTH, ADOPTION OR FOSTER CARE

Purpose of form: The below-named employee is requesting a leave of absence due to pregnancy, childbirth, care for a child after birth, adoption or foster care placement. This form will provide the University of Central Oklahoma with information needed to determine if the employee's requested leave is for a qualifying reason. Section II must be completed by the health care provider.

Instructions to employee: For Human Resources to consider your leave request as FMLA, this form must be completed by your physician and returned to the HR office.

This form should be completed and returned within 15 calendar days. You may return the form in person, by mail or by fax. The fax number for Human Resources is 974-3827.

Section I – To be completed by the Employee	
Employee's Name	Employee's Job Title

Section II – To be completed by the Health Care Provider

Instructions to the Health Care Provider: Your patient (our employee) is requesting leave under the FMLA due to pregnancy, childbirth, care for a child after birth, adoption or foster care placement. Please answer the following questions based upon your medical knowledge, experience and examination of the employee. Be sure to sign and date the form.

Health Care Provider's Name	
Business Address	
Telephone	Fax

Part A: Medical Facts:

1) Approximate date condition commenced: _____

   Probable duration of condition: _____

2) Is the medical condition pregnancy? ____ No ____ Yes If so, expected delivery date _____

3) Use the information provided by the employee in Section I to answer this question. If the employee fails to provide a list of their essential functions or a job description, answer these questions based upon the employee's own description of her job functions.

Is the employee unable to perform any of her job functions due to the condition: ____ No ____ Yes
If so, identify the job functions the employee is unable to perform: _____

_____

4) Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment.) _____

_____

Part B: Amount of Leave Needed:

5) Will the employee be incapacitated for a single continuous period of time due to her medical condition, including any time for treatment and recovery? ____ No ____ Yes

If so, estimate the beginning and ending dates for the period of incapacity:_____

_____

6) Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ____ No ____ Yes

If so, are the treatments or the reduced number of hours of work medically necessary?
_____ No ____ Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment including any recovery period:_____

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____hour(s) per day; _____ days per work from _____ through _____

7) Will the condition cause episode flare-up periodically preventing the employee from performing her job functions? ____ No ____ Yes If so, explain:

Additional Information: _____

_____

_____ _____
Signature of Health Care Provider Date