Form created October, 2003

Certification of Attending Doctor[1] – University of Oklahoma Shared Leave Program

I request that the information described on this form be provided so that I may be considered to receive paid leave rather than unpaid leave.

______________________________	______________________________
Printed name of patient	Signature of patient (or authorized representative)

1. Please state in layperson's terms the **medical facts** describing the patient's health condition[2]. Include in a brief narrative the **history** of the condition, the **date** the condition commenced or was diagnosed, and its **cause** if this is not apparent from the description of the condition.

2. What is the probable **duration** of the condition, or the probable duration of the patient's present **incapacity**[3] if different?

3. Will it be necessary for the patient to work **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 5 below)? If yes, give the probable duration:

[1] An "attending doctor" is a doctor of medicine or osteopathy.
[2] Here and elsewhere on this form, the information sought relates only to the condition for which the patient is requesting shared leave.
[3] "Incapacity," for purposes of the shared leave program, means inability to work due to the health condition, treatment therefor, or recovery therefrom.

4. If the condition is **chronic**, state whether the patient is presently incapacitated[3] and the likely duration and frequency of **episodes of incapacity**[3]:

5. a. If the patient will be absent from work on an **intermittent** or **part-time** basis because of **treatment** related to the condition, please estimate the probable number of treatments, the intervals between such treatments (including dates, if known), and the period required for recovery, if any:

   b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

6. a. Is the patient **unable to perform work** of any kind?

   b. If able to perform some work, is the patient **unable to perform any one or more functions of the job** (the patient should supply you with information about the functions of the job)? If yes, please list the essential functions the patient is unable to perform:

Signature of attending doctor	Date	Telephone number
Printed name of attending doctor	Type of practice	
Address	City, State, Zip	