

THE UNIVERSITY OF TULSA
CERTIFICATION OF HEALTH CARE PROVIDER
(Family and Medical Leave Act of 1993)

FOR EMPLOYEE

This form is to be completed by the health care provider and should be submitted to the Office of Human Resources with the Employee's Request for Leave of Absence form. The information sought relates only to the condition for which the employee is taking FMLA leave.

Employee:

I hereby authorize the following physician to provide the requested information related to my health and well-being in order for me to be approved for medical leave as required by the Family Medical Leave Act of 1993. I understand that release of this information will be disclosed to a third party and may no longer be protected by federal or state laws that are currently in effect, particularly the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that I may revoke this authorization at any time by submitting my request in writing to the Office of Human Resources.

Print Name of Health Care Provider

Signature of Employee

Date

SECTION I

Physician must complete if certification relates to the employee's serious health condition.

1) Employee's Name

2) Patient's Name

3) Date Condition Commenced

4) Probable Duration Of Condition

5) Does the patient's condition qualify as a "serious health condition" under any of the following categories? (The attached sheet describes the "serious health" definitions and other significant terms under the Family Medical Leave Act.)

- 1) Hospital Care
- 2) Absence Plus Treatment
- 3) Pregnancy
- 4) Chronic Conditions Requiring Treatment
- 5) Permanent/Long-term Conditions Requiring Supervision
- 6) Multiple Treatments (non-chronic condition)
- 7) Other, please specify _____

6) Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the above categories:

7) If additional treatments will be required for the condition, provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

8) If a regimen of continuing treatment by the patient is required under your supervision or by another health care provider, please provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

SECTION II

Physician must complete if certification relates to the employee's serious health condition.

Yes No 9) If medical leave is required for the employee's absence from work because of the employee's own condition (including absence due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? If "Yes," please indicate the approximate date the employee will be able to return to work:

Yes No 10) If able to perform some work, is the employee unable to perform the essential functions of the employee's position (the employee or the employer should supply you with information about the essential functions). If "yes," please list the essential functions the employee is unable to perform:

Yes No 11) Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment)? If "Yes," give the probable duration and recommend a schedule for a reduced leave of absence.

SIGNATURES

(Signature of Health Care Provider)

(Date)

(Print Name of Health Care Provider)

(Type of Practice)

(Address)

(Telephone Number)

**THE UNIVERSITY OF TULSA
MEDICAL AUTHORIZATION**

I, _____, do hereby authorize my health care provider to furnish to The University of Tulsa (hereinafter "TU"), 800 South Tucker Drive, Tulsa, OK 74104-3189, all medical records, reports, medical charts, laboratory records and reports, x-rays and x-ray readings and reports, and any and all records pertaining to my medical case, history, condition, treatment, diagnosis or expenses, including my psychological status to the extent any such information has a bearing on my ability to perform the responsibilities and expectations of the essential functions of my position as a _____ (title) at TU. The purpose of the requested disclosure is .

I also authorize TU, any of its employees, representatives and agents, to release information to my health care provider, including records and statements, regarding related background information giving rise to the request for reasonable accommodation and/or medical leave related to this medical authorization.

I acknowledge that the law of the State of Oklahoma provides that the information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome ("AIDS") and/or mental health information.

I also acknowledge that the persons or entities authorized to receive the information above is not a health care provider, that the information is being disclosed to a third party and that the information may no longer be protected by federal or state laws that are currently in effect, particularly the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that I may revoke this authorization at any time by submitting my request in writing to the Office of Human Resources.

A facsimile or photocopy of this form will have the same force and effect as the original signed copy.

Print Name of Employee

Signature of Employee

Date

Serious Health Condition

Family and Medical Leave Act of 1993 Definitions

A Serious Health Condition means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1) **Hospital Care**

Inpatient care (e.g., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2) **Absence Plus Treatment**

A period of incapacity¹ of **more than three consecutive calendar days** (including any subsequent treatment period of incapacity¹ relating to the same condition), that also involves:

- a) **Treatment² two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders, or on referral by, a health care provider; or
- b) **Treatment** by a health care provider on at least one occasion which results in a **regimen of continuing treatment³** under the supervision of the health care provider.

3) **Pregnancy**

Any period of incapacity¹ due to **pregnancy**, or for **prenatal care**.

4) **Chronic Conditions Requiring Treatments**

A chronic condition which:

- a) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
- b) Continues over **an extended period of time** (including recurring episodes of a single underlying condition); and
- c) May cause **episodic** rather than a continuing period of incapacity¹ (e.g., asthma, diabetes, epilepsy, etc.)

5) **Permanent/Long-term Conditions Requiring Supervision**

A period of **incapacity¹** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6) **Multiple Treatments (Non-Chronic Conditions)**

Any period of absence to receive **multiple treatments** (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, or for a condition that would likely **result in a period of incapacity¹ of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

¹ "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

² "Treatment" includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

³ A "regimen of continuing treatment" includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.