Certification From Attending Physician  **The University of Oklahoma Shared Leave Program**

What Is This Form For? Employees experiencing a catastrophic or life threatening illness that limit their ability to work do not always have enough paid leave hours to cover their illness-related time off. These employees have the option to request a donation of paid leave from the University of Oklahoma Shared Leave Program. This is a university-sponsored and employee-managed program which OU staff can voluntarily donate leave hours to a shared leave pool. The Employee Shared Leave Committee manages the leave pool and awards leave time based on need and availability. The information requested on this form is needed to help the shared leave committee make their decision. Thank you for taking the time to provide the information requested. When completing this form please only provide the information requested related to the condition for which the employee is requesting Shared Leave. If you have any questions about the form or this process, please contact OU Human Resources (Norman: 405-325-2961, HSC: 405-271-2180, Tulsa: 918-660-3190).

Please provide information requested on this form so that I may complete my application to the Shared Leave Program.	
Patient's First Name:	Patient's Last Name:
→ Patient's Signature (or authorized representative) Authorizing Information	Date:

Please Attach The Following Information To This Form:

1. Explain in layperson's terms the medical facts describing the patient's condition. 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 if different?

3. Will it be necessary for the patient to work intermittently or to work on a less than full-time schedule as a result of the condition (including for treatment described in Item 6 below)? If yes, give the probable duration.

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

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

6. Is the patient unable to perform work of any kind? ○ Yes ○ No

7. If the patient is 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 job functions the patient is unable to perform.

Print Physician's Name:		Type of Practice:
Location Address:		
→ Physician's Signature:	Date:	Contact Phone:

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