Oklahoma Department of Corrections Health Care Provider Statement

To the Health Care Provider:

The referenced patient has requested approval to cover an absence from work with sick leave or other approved leave program that may be substituted for sick leave. The Oklahoma State Merit Rules for Employment permit such leave usage only "when the employee cannot work because of sickness, injury, pregnancy, or medical, surgical, dental or optical examination, or treatment, or where the employee's presence at work would jeopardize the health of the employee or others."

Please complete this form and provide to the employee to return to his/her supervisor. Upon receipt of the information provided, a decision will be made whether to approve the employee's request for leave.

Part A:Name of Patient: Name of Health Care Provider: Provider's Address:	
Provider's Telephone #:	
Part B: Yes or No For the date(s) specification unable to work due to sickness medical/surgical/dental/optical examination or employee's presence at work would jeopardize or others.	ss, injury, pregnancy, treatment, or because the
Date(s) unable to work: From To on the following appointment	
Date/time Date/time Date/time Date/ti	ime Date/time
Part C: Yes or No This absence was consistent with the serious health condition proffice as requiring intermittent family and medical	previously certified by your
I certify that the above information is true and correct.	
Signature of Health Care Provider	Date (R 2/06)

Distribution: To Personnel File