Central Community School System

Sick Leave/Extended Sick Leave Request

Health Care Provider Form

To Be Completed by Employee

Employee Name: ____ Date of Request: _________________

School/Department: ______________________________________ Employee ID # __________________

Teaching Area or Job Title: ____

To Be Completed by Physician

Does the employee's condition prevent him/her from performing the essential functions of his/her job?

______YES ______NO

If yes, please state the medical facts relating to employee's condition __________________________________

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Provide a general description of treatment such as estimated dates of treatment and period required for recovery

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Leave dates medically necessary for the employee to be absent from work:

Date leave begins: __________________________ Date leave ends: ________________________

Any additional comments:____

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Signature Authorization

Employee's Signature: ___________________________________ Date: ______________

I herby state the above information is true and correct and I authorize release of the information requested on this form.

Health Care Provider Name (Please Print): _____________________________________

Health Care Provider Signature: ____ Date: ______________

Type of Practice: ____

Address: ____

Telephone Number: _______________________________ Fax Number: ___________________________

PLEASE RETURN COMPLETED FORMS TO:
CENTRAL COMMUNITY SCHOOL SYSTEM
POST OFFICE BOX 78094
CENTRAL, LA 70837