PROFESSIONAL STAFF TEMPORARY DISABILITY LEAVE

(Certification of Health Care Provider for Eligibility for Temporary Disability Leave Bank Days)

1.	Patient's/Employee's Name:
2.	A **"serious health condition"** for the purposes of this form is an illness, injury, impairment or physical or mental condition that requires an employee to miss ten (10) or more consecutive days of work and/or renders the employee unable to perform the essential duties of his or her job. Does this employee have a serious health condition and how many days of leave does the employee require before he or she could be reasonably expected to be able to perform the essential duties of his or her job?
3.	State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity** if different):

I verify that I am a licensed physician and that, for the reasons identified herein, the patient/employee is temporarily unable to perform the essential duties of his/her job.

Signature of Physician: _____ Type of Practice: _____

Address: _____ Telephone Number: _____

_____ Date: _____

FILE: GCBDAA-AF1
Basic

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Note: The reader is encouraged to review policies and/or procedures for related information in this administrative area.

Implemented: 05/20/2008

Revised: 03/24/2011

Hillsboro R-III School District, Hillsboro, Missouri