DeSoto County Schools

REQUEST FOR TEMPORARY MEDICAL LEAVE OF ABSENCE

This form is for medical leave available to employees who do not qualify for FMLA for the purposes defined in Board of Education Policy GBRIE. 1) Please complete the "Employee" section below. 2) Have your health care provider complete the "Certification" section below. 3) Return the form to Desoto County Schools, Employee Services Department, 5 East South Street, Hernando, MS 38632. You may also fax the form to (662)449-7236.

-----EMPLOYEE-----

Employee Name: _____ SS#_____

Home Address: _____
Street Address, City, State, Zip Code

Work Site: _____ Position: _____

Requesting leave from: ____/____/____ through ___/___/___. I will return to work on: ___/___/___.

Reason for requesting leave: _____

Employee Signature: _____ Date: _____

-----CERTIFICATION OF HEALTH CARE PROVIDER-----

Health care provider is a doctor of medicine, chiropractic or osteopathy legally authorized to practice by the appropriate examining board. *Provider should complete either Section I or II or III and Section IV.*

SECTION I – MATERNITY

Anticipated Delivery Date: _____ Anticipated Period of Postpartum Disability: _____

If the patient has or is expected to have an abnormal medical condition during the pregnancy that warrants limitations in work related activity or that requires an extended postpartum period, please explain why. *Attach additional pages if necessary.*

SECTION II – EMPLOYEE DISABILITY

Date disability began: ___/___/___ Probable duration or ending date: ___/___/___

Please describe the health condition(s) that make the employee unable to perform the essential functions of his/her job:

_____
_____Attach additional pages if necessary.

SECTION III – CARE OF FAMILY MEMBER

Name of Family Member: _____

Employee's presence is necessary to care from ___/___/___ to ___/___/___.

Please describe the serious health condition of the family member: _____
_____ Attach additional pages if necessary.

SECTION IV – HEALTH CARE PROVIDER

Name: _____ Phone: _____ License #: _____

Address: _____

Signature: _____ Date: _____

_____ _____
Principal/Director Signature Date Employee Services Approval Signature