REQUEST FOR LONG-TERM LEAVE

(This form is for employees who are employed a total of 1250 hours or less within a year.)

Name: _____
Last First Middle

Address: _____
Street City GA Zip

Phone Number: _____

Position: _____

Work Location: _____

Estimated Date of Return: _____

_____
Employee Signature Date

I recommend that this employee be considered for a long-term leave of absence.

_____
Supervisor's Signature Date

Physician's statement of disability (MS 66-005) is required.

This form must be returned to the Human Resources Department, Franklin County Schools, 280 Busha Road, Carnesville, GA 30521.

HR Approval:_____

Please type or print clearly in ink

Georgia Department of Community Health
State Health Benefit Plan

Disability Certification

P.O. Box 1990
Atlanta, Georgia 30301

I. Employee Identification.

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Last Name | First | Initial

Apartment/Box/Route

Street Address

City, State | Zip Code (5-digit + 4-digit)

County of Residence | Daytime Telephone Number ( )

II. Patient Identification.

Does this certification relate to the employee? ☐ Yes ☐ No

OR

Does this certification relate to a seriously ill family member? ☐ Yes ☐ No

If the certification relates to a seriously ill family member, provide the following information:

Last Name | First | Initial

Relationship to Employee | Date of Birth (Month | Day | Year)

III. Physician Statement.

Complete for the patient in Section II

- If the patient is the employee, will the patient be able to perform normal job duties during the period of disability? Yes ☐ No ☐
- If the patient is not the employee, is the employee's presence necessary or beneficial to the care of the patient? Yes ☐ No ☐
- If the disability is due to pregnancy, please give expected date of delivery. _____
- If the disability period exceeds two weeks prior to delivery or six weeks after the delivery, please give detailed medical information that supports the additional period of disability.
- Describe the disability - give diagnosis and detailed statement of patient's physical condition (Attach additional sheets if necessary.)

III. Physician Certification.

Physician's Name

Date Disability Begins (Month | Day | Year)

Estimated Date Disability Ends (Month | Day | Year)

Group Name

Suite | Daytime Telephone Number ( )

Street Address

I certify that the above named patient is under my care. Adjustments in these dates may be necessary at a later date.

Physician's Signature (No Stamps, Please) | Date

SHBP 66-005 (Rev. 03/02)