COLDSPRING – OAKHURST CONSOLIDATED ISD
LEAVE REQUEST

Medical Certification by Health Care Provider

Print or Type

Employee name	Patient name (if different from employee)
Diagnosis (nature of illness or injury)	
Date condition commenced _____ Probable duration of condition _____ Are you the attending physician for this illness? Yes No If no, physician's name _____ Is patient still under your care for this condition? Yes No	**If hospitalized:** Date admitted _____ Date discharged _____

Employee's condition

Is the employee unable to perform work of any kind? Yes No
If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? Yes No
If yes, list _____

Is it necessary for the employee to be absent from work for treatment? Yes No

Will it be necessary to work intermittently or on a less than full schedule? Yes No

If yes, give probable duration _____

Care for family member

Does the patient require assistance for basic medical or personal needs or safety, or for transportation? Yes No

If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? Yes No

If the patient will need care only intermittently or on a part-time basis, indicate the probable duration of this need _____

Date patient can return to a regular schedule (i.e. work/school)

Health Care Provider Name/Title (print) _____

Health Care Provider Signature _____ Date _____