TEMPORARY DISABILITY LEAVE REQUEST FORM

EMPLOYEE SECTION

Employee ID: _____ Position: _____

Last Name: _____ First Name: _____ Middle Initial: ____

In order for us to determine whether your absence qualifies as temporary disability leave, you must return this form to us by _____. If sufficient information is not provided in a timely manner your leave will denied.

_____ _____

Employee Signature Date

PHYSICIAN'S STATEMENT

Describe the nature of illness or injury: _____

_____

Is this condition due to a pregnancy? _____ Yes _____ No

Date first treated for this condition: _____

Was the employee hospitalized? _____ Yes _____ No

If hospitalized give dates, name and address of hospital below:

Name of hospital: _____ Date Admitted: _____

Address of hospital: _____ Date Discharged: _____

Is patient still under your care? _____ Yes _____ No

According to the patient's job responsibilities with GCCISD, are they able to return to work to perform the essential functions of their job? _____ Yes _____ No

First day patient unable to work? _____

Anticipated date patient can return to work? _____

_____ _____

Date Type of Practice

_____ _____

Signature of Physician Address