FILE: GBC-E-2

**Leave Request**

**Health Care Provider’s Statement Form**

**Staff Member Name:** Full Name

**Health Care Provider Name:** Health care Provider.

**Type of Practice/Specialty:** Practice

**Health Care Provider Phone Number:** Phone Number

**Health Care Provider Fax Number:** Fax Number

*The above named-individual, who is a staff member of Woodland Park School District Re-2, has informed the district that his/her health is such that a critical illness or injury may exist, which interferes with his/her ability to perform his/her present job duties. We have requested that this individual provide us with medical documentation substantiating his/her inability to continue working. Please complete this form and return to the staff member or fax to 719-687-8408.*

* Please state a medical diagnosis and prognosis:

* If a temporary leave of absence is recommended, what are the dates for this leave of absence?
  + Start Date:
  + Anticipated return-to-work date:
* **Restrictions:** Is the health of this individual such that he/she must permanently refrain from performing his/her normal job? \_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No
* **Medications:** Is the individual prescribed medication that may adversely affect the staff member’s ability to perform his/her duties? \_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_ N/A
* Additional considerations regarding this individual’s ability to perform his/her normal job duties:

**Health Care Provider’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_