Provo School District

SHORT-TERM MEDICAL LEAVE APPLICATION

To be completed by employee

Today's Date _____

Employee Name_____ Employee ID#_____

Address_____ City_____ Zip_____

Home or Cell Phone_____ Work Phone_____

Work Location_____ Position_____ Hrs/Day_____

Immediate Supervisor_____ Phone_____

Date of Employment_____ Years of Employment_____

Name of Healthcare Provider_____ Phone_____

Reason for Leave:

☐ A serious health condition that makes me unable to perform my essential job junctions; or

☐ Birth of a child Planning on returning Y_____ N_____

☐ FMLA Planning on returning Y_____ N_____

I am requesting Short-Term Medical Leave from: _____to_____
mm/dd/yy mm/dd/yy

Comments (optional)_____

_____

_____

Employee Signature_____**Date**_____

Supervisor Signature_____**Date**_____

Human Resources Signature_____**Date**_____

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HEALTHCARE PROVIDER VERIFICATION FORM

Short Term Medical Leave

To be completed by healthcare provider

Patient's Name_____DOB_____

Which of the categories below best describes the patient's condition:

- ☐ Hospital Care
- ☐ Permanent/Long-term Condition
- ☐ Chronic Condition with Intermittent Treatment
- ☐ FMLA
- ☐ Pregnancy
- ☐ Absence Plus Extended Treatment
- ☐ Treatment for Multiple Conditions
- ☐ Other

Please explain the medical condition identified above, including diagnosis and treatment:

When did the condition begin and what is the *expected* duration?

Will the condition require the services of a healthcare provider of an extended period of time: ___Yes ___No

Does this condition prevent the patient from completing the essential duties of his/her job? ___Yes ___No
(see attached job description)

The patient may:

- ☐ Work Full-Time
- ☐ Work Part-Time _____hrs/wk until_____(mm/dd/yy)
- ☐ Work Intermittently from_____to_____(mm/dd/yy)
- ☐ Not work at all from_____to_____(mm/dd/yy)

If work restriction(s) are directed, please indicate below, including duration of restrictions:

Healthcare Provider Name (Please Print) _____

Healthcare Provider Phone Number _____Fax Number_____

Type of Practice or Specialty _____

Healthcare Provider Signature _____Date_____

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RELEASE TO WORK AUTHORIZATION FORM

Provo School District requires employees to provide evidence that they are able to perform the essential job functions outlined in their description(s) after a medical leave of absence. This insures that no physical conditions exist that:

- Prevent the employee from performing his/her duties
- Endanger the employee's safety or health
- Endanger other's safety or health

To the Employee:

1. Prior to returning to work, provide this form, along with written copy of your job description, to your physician.
2. Have the physician complete the bottom portion of this form according to your job description.
3. Return the completed form to the Provo School District Personnel Office seven (7) days prior to returning to work.
4. All information gathered during the evaluation will be kept confidential in a medical file, apart from the regular employee Personnel File.

Name of Employee _____ Date of Birth _____

Position held in Provo School District _____

To the Physician:

Please read the attached job description for the person listed above and certify that he/she can perform the essential job functions of the position for which he/she is assigned as listed in the job description. Please indicate any restrictions or limitations the employee may have related to this job.

I hereby certify that on _____ I examined _____

and found him/her to be fit to perform the essential job functions of the position for which he/she is assigned and release him/her to return to work as specified:

☐ Without limitation on _____(mm/dd/yy)

☐ Return to work on _____(mm/dd/yy) with the following restriction(s)

_____

_____

and may return to work on_____ (mm/dd/yy) without limitation

_____ _____

Signature of Physician Date

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