

LONG TERM SICK LEAVE FORM (Employee)

Lower Kuskokwim School District
Personnel & Student Services
P.O. Box 305 * Bethel, Alaska 99559
(907) 543-4886p (907) 543-4900f

A. To be completed by EMPLOYEE:

Employee Name _____ Site & Position _____

I ___ have filed ___ will file a 'Leave Request form' with the Personnel office in addition to this form.

B. TO BE COMPLETED BY ATTENDING PRIMARY HEALTH CARE PROVIDER:

1. The above named employee was examined on (date) _____

2. Medical necessity:

Medical services were/are required: Yes No
If required: Immediate/Emergency Urgent Not Urgent

3. Was/Is the employee able to work full-time? Yes No Yes, with restrictions

a. If "no", I certify that from _____ to _____, the above named employee was/will be unable to perform the physical requirements of his/her work due to being medically incapacitated
Totally Partially

b. If "yes with restrictions", describe restrictions and anticipated duration:

4. Please indicate if other specialty services will be part of treatment: Yes No
If yes, please describe:

5. Please indicate any other restrictions or follow-up services that the employer may need to accommodate related to patient's condition.

PRINTED Name of Primary Health Care Provider Address and Phone number

Signature-Primary Health Care Provider Date

Form must be faxed (marked CONFIDENTIAL) to the attention of LKSD Personnel Dept. at 907-543-4900 directly from the Health Care Provider