

**LONG TERM SICK LEAVE FORM (Family Member)**

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 (FAMILY MEMBER):**

Patient Name \_\_\_\_\_ Relationship to 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 patient was examined on (date) \_\_\_\_\_

2. Medical necessity:

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

I certify that from \_\_\_\_\_ to \_\_\_\_\_ the above named employee is needed to care for the ill family member

3. Does the patient require assistance for basic medical, personal or safety needs? Yes No  
If yes, please describe:

4. Does the patient require other specialty services as 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**