GORE BOARD OF EDUCATION POLICY

DECA-E9

FAMILY MEDICAL LEAVE BANK FORM
1. Employee's Name: ---------------------------
2. Patient's Name: ------------------------
(if other than employee)
3. Diagnosis: (be specific and detailed)
____

4. Date you first treated this person: _______________________

5. Probable duration of condition and treatment:____

F AMIL Y MEMBER ILLNESS
If this certification relates to care for the employee's seriously-ill family member.answer
6, 7, 8, 9 and 10; if it does not skip to items 11 through 14.

Circle YES or NO in the spaces below as appropriate:

6. YES NO Is in-patient hospitalization of the family member required?
7. YES NO Does the family member require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
8. YES NO Is the employee's presence necessary and would be beneficial for the care of the family member?
9. Estimate the period of time care is needed or the employee's presence would be beneficial:
____

10. State a Prognosis for this employee's illness. Be as specific as possible and indicate an approximate time when the employee will be able to return to work.

ILLNESS OF AN EMPLOYEE OF GORE SCHOOLS

11. YES NO Is in-patient hospitalization of the employee required?
12. YES NO Is the employee able to perform work of any kind?
13. YES NO Is the employee able to perform the function of employee's position? (see attacked Job /Physical Description)
14. State a Prognosis for this employee's illness. Be as specific as possible and indicate an approximate time when the employee will be able to return to work.

[attach information sheet if necessary]

SIGNATURE OF PHYSICIAN: __________________________________
(signature)
(typed 'or printed name) ___________________________________
Date this information was provided.________________________________
[This information is required by the GORE BOARD OF EDUCATION in compliance with guidelines listed in F AMILY MEDICAL Leave Act.