NEWPORT NEWS PUBLIC SCHOOLS

Leave of Absence Physician Statement

Clear Form

Leaves of Absence are provided to eligible employees under the provisions of NNPS School Board Policy GCCA attached with proper physician certification.

Employee ID #: _____ Employee Name: _____

Job Title: _____Work Location: _____

Supervisor Name: _____

Is this a continuation of a condition for which the Family Medical Leave Act (FMLA) was used?

☐ Yes ☐ No

By signing below, the employee authorizes the provider to submit the requested information to the employer.

Employee/Patient Signature: _____ Date:_____

Health Care Provider Information:

Provider's name and business address: _____

Type of Practice/Medical Specialty: _____

Telephone: (___)_____ Fax: (___)_____

Email: _____

Duration of Leave:

1. Approximate date condition began: _____
2. Probable duration of condition: _____
3. Responses to the following questions should be based on the essential functions contained in the employee's current job description or the employee's own description of his/her job functions.
4. Is the employee unable to perform any of his/her functions due to the condition?:
   ☐ Yes ☐ No
5. If yes, identify the job functions the employee is unable to perform:

   _____

6. Describe other medical facts, if any related to the condition for which the employee seeks leave (such medical facts may include symptom, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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7. Please attach any documents that are relevant to the evaluation of the request for Medical Leave of Absence.

Signature of Health Care Provider:_____ Date:_____