JASPER COUNTY BOARD OF EDUCATION

Request For Family Leave

(Please type or print clearly in ink.)

Health Care Provider MUST complete Part 4 AND Part 5 OR Part 6

** *PART 4* **

IDENTIFICATION OF HEALTH CARE PROVIDER

Physician's Name _____

Address _____

City, State _____ Zip Code _____

Telephone Number _____ License Number _____

** *PART 5* **

CARE OF FAMILY MEMBER

Name of Family Member _____ Relationship to Employee _____

Date(s) employee presence necessary for family member: from _____ (Beginning Date) to _____ (Ending Date)

Describe the serious health condition of family member. Attach additional page(s) if necessary:

_____

_____

_____

_____

** *PART 6* **

EMPLOYEE DISABILITY

Employee Name _____

Date The Disability Commenced _____ Probable Duration or Ending Date _____

Describe the serious health condition that makes the employee unable to perform the essential functions of his/her employment. Attach additional page(s) if necessary:

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date of Health Care Provider's Signature**