# Family Medical Leave Request/Approved Medical Leave Request

*Employee completes this page and forwards request form, along with a job description, to the health care provider to complete the Attending Physician's Statement. Contact the Human Resources Department for a copy of your job description. Once the employee and health care provider information is complete, the request form is sent to Human Resources for review.*

Employer: Friendswood ISD
Contact: Leah Tunnell
*Executive Director of Human Resources*
302 Laurel Drive, Friendswood, TX 77546
281-482-1267

## EMPLOYEE INFORMATION

Please complete before giving this form to your medical provider.

| | |
|---|---|
| Name: *First* *MI* *Last* | |
| Position: | Campus or Department: |
| ☐ Full-time ☐ Part-time ☐ Hourly ☐ Bus Driver | |
| Approximate date for leave to begin: / / | |
| Anticipated date of return to work (if known): / / | |
| ☐ **PLEASE CHECK THIS BOX IF YOU HAVE SHORT TERM DISABILITY BENEFITS WITH FISD** | |

**I have attached a copy of my job description for the attending physician's review.**

/ /

**Signature** **Date**

## NOTE TO ATTENDING PHYSICIAN:

Your patient has requested a medical leave of absence. Answer, fully and completely, all applicable parts. Several questions seek a response as to frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA or Temporary Disability Leave coverage. Limit your responses to the condition for which the employee is seeking leave. **Please be sure to sign the form at the bottom of the page.**

| **FOR FISD HR OFFICE USE ONLY:** | |
|---|---|
| Date request received: / / | Request form complete: ☐ Yes ☐ No |

## Attending Physician's Statement

To be completed by Physician. (Please print)

| Name of Patient: | Date of Birth: / / |
|---|---|

### DIAGNOSIS

Diagnosis:

Is requested leave the result of pregnancy? ☐ Yes ☐ No

Date of delivery (if delivered): / / Expected delivery date: / /

### TREATMENT

Approximate date condition commenced: / / Probable duration of condition:

Will patient need treatment appointments at least twice per year due to the condition? ☐ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment? ☐ Yes ☐ No
If yes, state the nature and expected duration of treatment:

Was medication, other than over-the-counter, prescribed? ☐ Yes ☐ No

Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility? ☐ Yes ☐ No

### PROGNOSIS

***Please use the information provided in the attached job description to answer the following questions. If employer fails to provide a list of essential functions or a job description, please answer based upon the employee's own description of his/her job functions.***

Is the employee unable to perform and of his/her job functions due to the condition? ☐ Yes ☐ No
If so, identify the job functions the employee is unable to perform:

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (including, symptoms, diagnosis or any regimen of continuing treatment such as the use of specialized equipment:

### LENGTH OF LEAVE REQUIRED

Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including time for treatment and recovery? ☐ Yes ☐ No
If so, estimated dates for the period of incapacity: / / to / /

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No
If so, are the treatments or reduced work hours medically necessary? ☐ Yes ☐ No

Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:
hour(s) per day; days per week from / / through / /

Will the condition cause episodic flare-ups, preventing the employee from performing his/her job functions? ☐ Yes ☐ No

If yes, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months:

Frequency: _______ times per _______ week(s) _______ month(s)

Duration: _______ hours or _______ day(s) per episode

Is it medically necessary for the employee to be absent from work during these flare-ups? ☐ Yes ☐ No

If yes, please explain:

### ADDITIONAL INFORMATION (if needed)

### PHYSICIAN INFORMATION

| Attending Physician's Name & Specialty: (print) | Telephone #: ( ) | Fax #: ( ) | |
|---|---|---|---|
| PO Box or Street Address: | City: | State: | Zip Code: |

/ /

**Signature** **Date**