Medical Leave Request Form Educator Certified

All medical leave request should be made at least 30 days prior to the date leave is set to begin (if possible). Any medical leave

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Arlington Independent School District
Certification of Health Care Provider Form
Temporary Disability Leave

Employee's name:	Patient's name:
Employee's Department	Employee's Position

The section below should be completed by the Attending Physician or Practitioner:
The information requested on this form relates only to the serious health condition for which the employee is requesting leave.
Please check the applicable category of the patient's qualifying condition:

Hospital Care Admission to Hospital Date: Discharge Date:

Serious Health Condition (Absence Plus Treatment)

Birth of a Child Estimated Date of Delivery

1. Length of time your patient has had/will have this condition (Keeping the employee from essential functions of his/her job):

   From: Through:

2. Describe the health condition and regimen of treatment to be prescribed indicating the number of visits, general nature and duration of treatment, and including referral to other provider(s) of health services.

Print of Type Name of Healthcare provider:	
Type of Practice:	
Street & Mailing Address:	
Telephone Number:	Fax Number:
Signature of Healthcare Provider:	Date:

Return

HIPAA AUTHORIZATION FORM

Employee's Full Name	Social Security Number
Address	Employee ID Number
City, State Zip Code	Date of Birth
Telephone Number	Email

I authorize the use or disclosure of my protected health information as described below.

1. The specific information that should be disclosed is (please give dates of service if possible)

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