Leave Request
Health Care Provider's Statement Form (GBC E 3)
(Need to Care for Family Member)

Staff Member Name: _____

Family Member's Name: _____ Relationship to Staff Member: _____

Health Care Provider Name: _____

Type of Practice/Specialty: _____

Health Care Provider's Phone Number: _____ Fax Number: _____

The above named individual, who is a staff member of Academy District 20, has informed the district that his/her presence is required to care for a critically ill or injured family member. We have requested that this individual provide us with medical documentation substantiating the necessity of his/her presence to care for a critically ill or injured family member. **Please complete this form and return to the staff member or fax to 719-234-1705.**

1. Please indicate whether the individual named above as the staff member is needed to care for the critical illness or injury of a family member who is your patient.

   _____

   _____

   _____

   _____

   _____

2. Is the patient's critical illness or injury of a life threatening nature?
   ☐Yes ☐No

3. If a leave of absence is recommended for the staff member to care for the critically ill or injured family member, what is the anticipated duration of the leave (start date of leave and projected end date)?

   _____

   _____

   _____

_____ _____
Health Care Provider's Signature Date

Revised: March 31, 2010; July 1, 2011; July 1, 2013; July 1, 2016; July 1, 2019; July 1, 2024