

Physician or Practitioner Certification

Anchorage School District

Employee - Serious Health Condition

Employee SS#

Employee Last Name

Employee First Name

Diagnosis:

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Birth of a child: *Please state the date and type of birth: (If prior to birth, please provide estimated date of delivery)*

Date condition commenced: _____

Probable duration of condition: _____

Is in-patient hospitalization required? Yes No

Is employee able to perform work of any kind? Yes No

Does employee's serious health condition require intermittent or reduced leave use? Yes No

Explain regimen of treatment prescribed: *(Indicate number of visits, nature and duration of treatment. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)*

Signature of Physician or Practitioner

Date

Print Name of Physician or Practitioner (include title)

Physician/Practitioner's Phone #

All documentation related to the employee's medical condition will be held in strict confidence and maintained in the employee's medical records file.

Please submit to:

Anchorage School District
Benefits Department - Leave Specialist
5530 E. Northern Lights Blvd.
Anchorage, Alaska 99504-3135