Physician or Practitioner Certification

Family Member - Serious Health Condition

Anchorage School District

Employee SS#	Employee Last Name	Employee First Name

Patient's Name	Relationship

Diagnosis:

Date condition commenced: _____

Probable duration of condition: _____

Is employee needed to care for family member? ☐ Yes ☐ No

Estimate the period of time care is needed or the employee's presence would be beneficial: _____

_____ _____

Signature of Physician or Practitioner: *Date*

_____ _____

Print Name of Physician or Practitioner: *Physician/Practitioner's Phone #*

TO BE COMPLETED BY THE EMPLOYEE

a. Explain the care you will provide:

b. Estimate the time period: _____

c. Include a schedule if leave is to be taken intermittently or on a reduced leave schedule.

Employee Signature *Date*

_____ _____

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