

Physician or Practitioner Certification

Anchorage School District

Family Member - Serious Health Condition

Employee SS#	Employee Last Name	Employee First Name
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Patient's Name	Relationship
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Diagnosis:

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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:

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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
Human Resources Department
P.O. Box 196614
Anchorage, Alaska 99519-6614