Leave Request
Health Care Provider's Statement
(Inability to Perform Essential Job Duties)

Employee: _____Date: _____

Physician: _____Type of Practice:_____

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

The above individual, who is an employee of The Classical Academy Charter School, has informed us that her/his health is such that limitations may exist in regard to performing her/his present job duties. We have requested that this individual provide us with medical documentation substantiating her/his ability to continue working. ***Please complete the following and fax to 719-488-6333.***

Please state a medical diagnosis and prognosis:

If a temporary leave of absence is recommended:

what is the start date for this leave of absence? _____(Date)

What is the anticipated return to work date? _____(Date)

Restrictions: Is the health of this individual such that he/she must permanently refrain from performing his/her normal job?

☐ Yes ☐ No

Medications: Is the individual prescribed medication that may adversely affect the staff member's ability to perform his/her duties?

☐ Yes ☐ No

Additional considerations regarding this individual's ability to perform her/his normal job duties:

Health Care Provider's Signature: _____ Date: _____