Leave Request – Care for Family Member
Health Care Provider's Statement

Section I: Employee

Employee: _____Date: _____

Family Member: _____Relationship: _____

Type of Care you will provide (Check all that apply):

- ☐ Assistance with basic medical, hygienic, nutritional or safety needs
- ☐ Transportation
- ☐ Physical Care
- ☐ Psychological Comfort
- ☐ Other:

If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced schedule you can work:

Section II: Physician

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 family member's health condition and need for care 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 family member's need for medical care and her/his ability to continue working. ***Please complete the following and fax to 719-488-6333.***

Please state a medical diagnosis and prognosis for the employee's family member:

what is the approximate date that the condition started or will start? _____

Provide your best estimate of how long the condition lasted or will last: _____

For a leave of absence to be approved, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient:

Will the type of medical care described above require continuous or intermittent leave from the employee's job duties in order for them to provide care?

- ☐ Continuous
- ☐ Intermittent

Health Care Provider's Signature: _____ Date: _____