Rev. 07/01/2021

BALDWIN COUNTY BOARD OF EDUCATION
LEAVE OF ABSENCE MEDICAL VERIFICATION

To be completed by a physician and submitted with the appropriate leave of absence request. This is a required form for all Leave of Absence Requests & Catastrophic Illness Requests unless the employee has provided the FMLA Medical Verification Form.

Please supply all requested information. Attach additional sheets if more space is needed to fully explain condition.

(Please type or print legibly)

Name: _____ Social Security Number: ***-**- _____

Employee Number: _____ Base School/Station: _____

Position: _____ Home Telephone Number: _____

Home Address: _____

CITY: _____ STATE: _____ ZIP: _____

Date illness/injury began: _____ Likely or anticipated, duration of the condition, illness or injury _____

Is this a catastrophic illness/injury? _____

Appropriate medical facts within the knowledge of the physician to substantiate the medical condition requiring a leave of absence, and if catastrophic, to substantiate the serious medical condition or catastrophic illness/injury: **(Attach additional sheets if more space is needed.)**

_____

_____

If employee is to care for sick spouse, child or parent, state conditions/reasons why employee must care for this person:

_____

_____

Due to the employee's health condition, and your understanding of the employee's job functions, is this employee able to perform the essential functions of the job? ☐ **YES** ☐ **NO**

If **NO**, can he/she do so with accommodations? ☐ **YES** ☐ **NO**

If **YES**, suggested accommodations: _____

Likely or anticipated Return to Work Date: _____

Name of Physician: _____ Office Telephone: _____

Office Mailing Address: _____

City: _____ State: _____ Zip: _____

By my ***signature***, I verify the employee named above is incapacitated due to the health condition, illness, or injury described above, and thereby unable to perform his/her job during the stated time period.

_____ _____

Signature of Heath Care Provider **(Stamps NOT accepted.)** **Date**