JUDICIARY LEAVE DONATION AND LEAVE BANK PROGRAM
MEDICAL CERTIFICATION/REQUEST FOR LEAVE FORM

Employee Name: _____ Social Security Number: _____

Date: _____ Work Location: _____ Job Title:_____

Date of onset: _____ Diagnosis:(Statement)_____

_____

Approximate date employee can return to: modified activities/duty _____ full activities/duty_____

Please describe reduced work schedule, if required _____

Summary of treatment and anticipated procedures, including number and frequency of any follow up treatments (attach additional sheets, if necessary): _____

_____

Limitations that may impact ability to perform work duties. (Attach additional sheets, if necessary, please indicate whether limitation is temporary or permanent.)

_____

_____

Physician's Name: _____ Signature:_____

(PRINTED OR TYPED)

Phone number: _____

Note: This document shall be treated as a confidential medical record and not placed in the employee's personnel file.

Based on the above information, I hereby request:

1) _____ hours of leave from the leave bank

2) _____ hours of donated leave

Employee's signature:_____ Date:_____

FORM MUST BE COMPLETED IN ITS ENTIRETY BEFORE REQUEST CAN BE REVIEWED.

Employee is: "Eligible to receive leave "Not eligible to receive leave (reason:_____)

(see Section V of the policy)

Signature of Administrative Supervisor: _____ Date: _____

Signature of Human Resources representative: _____ Date: _____

RESET FORM