HOBBS MUNICIPAL SCHOOLS FAMILY AND MEDICAL LEAVE ACT

EMPLOYEE APPLICATION FOR BENEFITS

TO BE COMPLETED BY EMPLOYEE:

PATIENT'S NAME: _____SSN_____

ADDRESS: _____PHONE: _____

SCHOOL CAMPUS: _____

I authorize Dr._____ to release further information to the Hobbs Municipal Schools if deemed necessary.

_____

Employee's Signature Date

TO BE COMPLETED BY PHYSICIAN:

Your patient is currently applying for leave with the Hobbs Municipal Schools through the Family and Medical Leave Act of 1993. The Hobbs Municipal Schools needs the following information to determine if the patient's medical condition meets the requirements defined by the Family Leave Act.

Date of onset of medical condition? _____

What is the nature and severity of the condition? _____

Is surgery needed to relieve this condition?

How long will the condition be acute? _____

How long will the patient need for convalescence? _____

Anticipated follow-ups visits? _____

During this time period, will the patient be:

☐Fit for Duty ☐Fit for limited duty ☐NOT fit for duty

LIMITATIONS: _____

- If NOT fit for duty, when do you project the patient would be fit for full duty? {Please give an approximate date) _____
- What would the limitations be at that time?

  _____
- When do you project the patient would be fit for full duty? (Please give an approximate date)

  _____

_____

Physician's Signature Physician's I.D. Number Date

Federal Family & Medical Leave Act: An employee on approved Federal Family and Medical Leave may continue to participate in all phases of the group insurance as long as the employee continues to pay his/her share of the premium. The Board will continue to pay their portion of the premium If the employee's portion is continued.