Little Rock School District
HUMAN RESOURCES DEPARTMENT
MEDICAL LEAVE UPDATE

HEALTH CARE PROVIDER

Employee Name: *(Print)*_________________________________ Patient Name: *(Print)*____________________________________

Please provide your contact information, complete all relevant parts of this form, and sign the form below.

Health Care Provider's name: *(Print)*____

Health Care Provider's business address: ____

Name of business: _____________________________ Type of practice/Medical specialty: ___________________________________

Telephone: ____________________ Fax: ____________________ Email: ____

- Please provide a brief update including any treatment regimen and progress made thus far and the medical reason for the continuation of the medical leave:

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- Please check the applicable reason and provide the timeframe of the extension you are requesting.

  — Due to the condition, the patient is **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery. *The timeframe cannot include indefinite, undetermined, not applicable, etc.*

  Provide your best estimate of the beginning date ___________ *(mm/dd/yyyy)* and end date___________ (mm/dd/yyyy) for the period of incapacity.

  — Due to the condition, it is medically necessary for the **employee** to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups.

  Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last. Episodes of incapacity are estimated to occur ____ times per (☐ **day** / ☐ **week** / ☐ **month**) and are likely to last approximately ________________ (☐ **hours** / ☐ **days**) per episode.

  — Due to the condition, it is necessary for the employee to be absent from work to **provide care for the patient** on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups.

  Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last. Episodes of incapacity are estimated to occur ____ times per (☐ **day** / ☐ **week** / ☐ **month**) and are likely to last approximately ________________ (☐ **hours** / ☐ **days**) per episode.

Signature of
Health Care Provider:____**Date:**__________________*(mm/dd/yyyy)*

Please return this form to the employee or send it to:
LRSD Human Resources Medical Leave
810 W. Markham
Little Rock, Arkansas 72201
Office: 501-447-1100
Fax: 501-447-1162