TEXAS CITY ISD EXTENDED LEAVE REQUEST FORM

Name:____ **Date:**___________________

Home Address:____
____

Campus/Supervisor:____

Beginning Leave Date______________________ **Estimated Return Date**_______________

Reason for Extended Leave Request:____
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____
____

Employee's Signature____ **Date:**______________

This form must be completed and returned to Human Resources within 15 days of the employees first day of leave.

Physician's Section:

This section must be completed by the attending physician or the physician's statement must be attached in order for leave to be approved.

This is to certify the above named patient is under my professional care and is unable to perform his/her required job duties beginning on ________________. The patient may return to work on____________________.

Nature of Disability or Illness/Physician Comments:____________________________________
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____
____

Physician's Name________________________________ **Phone #**_________________________

Address____

Signature____ **Date**________________________

Date received in Human Resources______________________ Approved________ Denied______

Signature:____ Date:________________________