

**Medical Necessity Remote Teaching Request Form**

Employee Name: \_\_\_\_\_

Position/Location: \_\_\_\_\_

District Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Date: \_\_\_\_\_

**Reason for Request**

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I understand I will be expected to meet the same requirements as the CPEs performing their educational duties in their assigned workspace, including, but not limited to the following:

CPE will prepare educational opportunities for their students to work on during the period of remote learning. This may include home packets, materials posted on Skyward Message Center, Google Classroom, or any other platform utilized by the CPE. These educational opportunities will also include instruction of how students and parents may contact the teacher during this time if questions arise (such as school email address). Building or District Administration will have full access to any student management platform utilized by any CPE. The primary Learning Management System utilized in grades 3rd-12th will be Google Classroom.

Each CPE will provide their building administration a copy of their educational plan, which may include hard copies of home packets or Google Classroom codes of classes upon request. PRE-K - 2nd grade will utilize tablets upon receipt.

On school days, each CPE will be available daily to monitor emails and/or other online educational forums for students, parents, and administrative questions during work hours as defined below. CPE's are expected to respond to any inquiries received within 24 hours during the workweek.

The hours of required synchronous and asynchronous instructional time for CPE's will be 4.5 hours per day. The times below reflect an included 30 minute lunch.

- Pre K-12 9:00-2:00
- Evening Academy - 4:00-8:30

**Please attach the accompanying Physician's Form to your request.**

**Physician's Form**

***To be completed by employee:***

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

*Release Statement: I hereby authorize the undersigned physician to release my medical records and provide verbal and written information regarding my examination or treatment to my employer, Granite City School District. I understand that this release constitutes a waiver of my rights to confidentiality to the extent stated above, pursuant to the Medical Patient Rights Act, 410 ILCS 50/3(d).*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_

\_\_\_\_\_

***To be completed by physician:***

This patient is under my care. Due to the following underlying condition(s), this patient is unable to be available for in-person work and should work remotely.

Briefly describe the illness/condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature Date