



JOSHUA INDEPENDENT SCHOOL DISTRICT
Medical Certification

Printed Name of Applicant _____

Number of Days Requested _____ beginning as soon as my allowable paid and other leave ends according to the administrative guidelines, unless noted below.

I have read and understand the rules related to the Board Policy and Administrative Guidelines.

I _____ **do** _____ **do not** authorize the Administration to request from the staff, electronically, or by any other means my request that a sick leave pool be set up should the administration agree that my request is a qualifying condition.

Signature of Applicant

Date

Signature on behalf of Applicant

Date

Physician's Use Only:

The above printed name of an employee of the Joshua Independent School District has requested a medical opinion as to why the above-named individual cannot perform duties and requires additional sick leave donated days from faculty and staff.

The medical reason(s) this individual cannot return to work include: _____

I anticipate the above-named individual will be out:

_____ Days, or

_____ Weeks, or

_____ Will Not return to work

Printed Name of Physician

Signature of Physician

Date

Office Use Only:

Approved: _____ Yes _____ No for _____ days for the _____ school year.

Signature of Superintendent

Date