

JOSHUA INDEPENDENT SCHOOL DISTRICT
Medical Certification for Temporary Disability Leave (TDL)

Employee Name _____ Position _____

Department/campus _____ Job description attached: ☐ Yes ☐ No

To be completed by the health care provider

Provider's Name: _____

Provider's Address: _____

Provider's Telephone: _____ Fax: _____

1. Approximate date condition commenced: _____

Probable duration of condition: _____

2. Is the medical condition pregnancy? Yes ___ or No ___

If yes, expected delivery date: _____

Is the employee unable to perform any of his/her job functions due to the condition?

Yes ___ or No ___ If so, identify the functions unable to perform:

3. Will the employee be incapacitated for a single continuous period of time due to his/her Medical condition, including any time for treatment and recovery? Yes ___ No ___

Please complete and Return to:
Joshua ISD Human Resources Department
Angela Clayton
Coordinator of Leaves, Benefits, & Compensation
claytona@joshuaisd.org
(p) 817-202-2514
(f) 817-641-2738

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If so, estimate the beginning and ending dates for the period of incapacity:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regiment of continuing treatment such as the use of specialized equipment):

Signature of Health Care Provider: _____ Date: _____

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