SHORELINE
PUBLIC SCHOOLS

Human Resources Department
18560 1st Avenue NE
Shoreline, WA 98155-2108
206-393-4329
Fax Number: 206-393-4218

Medical Documentation for Shared Leave

Return to Human Resources

I hereby authorize you to release the information requested to Shoreline Public Schools.

_____ _____
(Employee signature) (Date)

To the physician or authorized health care practitioner of _____
(Print name of employee, relative or household member)

_____ , an employee with Shoreline Public Schools, has applied for shared leave donations from other employees of Shoreline Public Schools under the district's shared leave program. In order to receive shared leave, and in accordance with WAC 392-136A-055, the district requires that the health condition causing the employee to apply for shared leave must be verified by a licensed physician or authorized health care practitioner as an illness, injury, impairment, or physical or mental condition that is of an **extraordinary, severe or life-threatening nature**. Please provide a short description of the health condition of the individual named above.

_____

_____

Expected duration of condition

Start Date: _____ Anticipated End Date: _____

Can you verify that this a condition of: **extraordinary, severe or life-threatening nature?**

☐ Yes ☐ No

Signature: _____ Date: _____
(Signature of health care provider)

Name: _____
(Print name of health care provider)

Address: _____