



EMPLOYMENT PHYSICIAN SERVICES
1720 Termino Avenue, Long Beach, CA 90804
(562) 494-0735 ♦ Fax: (562) 494-0733

REQUEST FOR STATUTORY LEAVE OF ABSENCE

*****Certificated*****

When an employee has used all accumulated leave balances (sick leave, vacation and vacation accrual) he/she shall submit this form requesting statutory leave and return it to the site Payroll Designee. The employee must then have their personal physician complete the Confidential Request form both for non-work related and work related medical absences, pending approval of the workers' compensation claim. Return completed forms to Physician Services. No request or physician's statement is necessary for the initial (one time use) of statutory leave for four (4) consecutive working days or less. No Confidential Request is required for maternity or pregnancy disability leave.

Statutory leave may not exceed one hundred (100) days per illness or injury.

I. EMPLOYEE'S STATEMENT (Please print or type - use payroll name)

Name (Last, First, MI) _____ Employee # _____

Home Phone Number () _____ Assignment Location _____ Position _____

Home Address (Street, City, Zip) _____

I hereby authorize my health care provider to release medical information to Juan A. Escobar, M.D.

Signature (Use Payroll Name) _____ Date _____

2. TO BE COMPLETED BY SITE PAYROLL DESIGNEE:

Employee is (check one): _____ 200 day _____ 202 day _____ 204 day _____ Track _____ 212 day
_____ 217 day _____ 12 month

Statutory leave to begin _____ Number of statutory leave hours used as of this date _____

Date 100 days of statutory leave balance used _____

ADMINISTRATIVE REVIEW:

Site Administrator _____ Date _____

3. ATTENDING PHYSICIAN'S STATEMENT:

(Please complete attachment - Confidential and return this form to the above address/fax)

Illness Surgery Injury Pregnancy Other _____

Anticipated date this employee will return to work (Month/Day/Year) _____

Physician's Address (Street, City, Zip) _____

Physician's Name (Please Print or Type) _____ Phone# () _____

Attending Physician's Signature _____ Date _____

4. LBUSD DISTRICT PHYSICIAN'S REVIEW: Approved Denied

Employment Physician _____ Date _____