EMPLOYMENT PHYSICIAN SERVICES
1515 Hughes Way, Long Beach, CA 90810
(562) 997-8425 ◆ Fax: (562) 997-8014

REQUEST FOR STATUTORY LEAVE OF ABSENCE

*****Classified*****

When an employee has used all accumulated leave balances (sick leave, vacation accrual, and personal/discretionary leave) 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.

Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) leave will run concurrent with statutory leave for eligible employees as permitted by law.

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. I understand that Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leave will run concurrent with statutory leave.

Signature (Use Payroll Name)_____Date_____

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2. TO BE COMPLETED BY SITE PAYROLL DESIGNEE:

Has the employee used all accumulated leave balances (sick leave, vacation accrual, and personal/discretionary leave)? Yes__ No__

Statutory leave to begin_____

ADMINISTRATIVE REVIEW:

Site Administrator_____Date_____

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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_____

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4. LBUSD DISTRICT PHYSICIAN'S REVIEW: ☐ Approved ☐ Denied

Employment Physician_____ Date _____

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CONFIDENTIAL REQUEST FOR SICK LEAVE, STATUTORY LEAVE OF ABSENCE AND RETURN TO WORK

To: Employee's Personal Physician

From: Juan A. Escobar, M.D.
Long Beach Unified School District Physician

To assist me in the administration of your patient's benefits, it is respectfully requested that you provide the following information relative to this employee's request for medical leave of absence. All information will be kept in strictest medical confidence. Thank you for your kind attention to this matter.

_____ _____ _____
Employee Name Date Employee Number

I (employee's signature)_____hereby authorize my health care provider to release medical information to Juan A. Escobar, M.D.

Diagnosis:

_____

_____

Does the patient's condition qualify as a "serious medical condition" under the Family and Medical Leave Act?

☐ Yes ☐ No

This patient:

☐ May not return to work

☐ May return to work on or after the following date:

☐ Full Duty: _____ (Date) ☐ Modified Duty: _____ (Date)

Please List Restrictions:

☐ None ☐ Permanent ☐ Temporary (_____Weeks_____Months)

Specific Restrictions:

_____

_____

_____

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

Physician's Name (*please print or type*) _____Phone # _____

Attending Physician's Signature _____Date _____

Please return this form to the above address/fax