Little Rock School District
HUMAN RESOURCES DEPARTMENT
MEDICAL LEAVE UPDATE

HEALTH CARE PROVIDER

Employee Name: *(Print)*_____ Patient Name: *(Print)*_____

Please provide your contact information, complete all relevant parts of this form, and sign the form below.

Health Care Provider's name: *(Print)*_____

Health Care Provider's business address: _____

Name of business: _____ Type of practice/Medical specialty: _____

Telephone: _____ Fax: _____ Email: _____

❖ Please provide a brief update including any treatment regimen and progress made thus far and the medical reason for the continuation of the medical leave:

_____
_____
_____
_____
_____
_____
_____

❖ Please check the applicable reason and provide the timeframe of the extension you are requesting.

— Due to the condition, the patient is **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery. *The timeframe cannot include indefinite, undetermined, not applicable, etc.*

Provide your best estimate of the beginning date _____ *(mm/dd/yyyy)* and end date_____ (mm/dd/yyyy) for the period of incapacity.

— Due to the condition, it is medically necessary for the **employee** to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups.

Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.
Episodes of incapacity are estimated to occur ____ times per (☐ **day** / ☐ **week** / ☐ **month**) and are likely to last approximately _____ (☐ **hours** / ☐ **days**) per episode.

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Provide your best estimate of the beginning date _____ *(mm/dd/yyyy)* and end date_____ (mm/dd/yyyy) for the period of incapacity

— Due to the condition, it is necessary for the employee to be absent from work to **provide care for the patient** on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups.

Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.
Episodes of incapacity are estimated to occur ____ times per (**day** / **week** / **month**) and are likely to last approximately _____ (**hours** / **days**) per episode.

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Provide your best estimate of the beginning date _____ *(mm/dd/yyyy)* and end date_____ (mm/dd/yyyy) for the period of incapacity

Signature of Health Care Provider:_____ **Date:**_____ ***(mm/dd/yyyy)***

— **Please return this form to the employee or send it to:**
LRSD Human Resources Medical Leave, 810 W Markham, Little Rock, AR 72201 - Phone 501-447-1101 (Fax) 501-447-1162