Clear Form

Miami-Dade County Public Schools
LEAVE OF ABSENCE MEDICAL DOCUMENTATION

For Completion by the EMPLOYEE:

_____
Employee Name / Employee Number

I hereby authorize Miami-Dade County Public School's healthcare representative to contact my healthcare provider for purposes of verification, clarification and/or authentication of the information on this form.

_____ _____
Employee Signature Date

The healthcare provider must indicate beginning and end dates of leave, otherwise your application will be considered incomplete, will not be approved and you may face disciplinary action or termination.

For Completion by the Healthcare Provider:

Your patient has requested an extended leave of absence. In providing the information, be specific. Terms such as "lifetime," "unknown," or "undetermined" are not acceptable. Employees on leaves of absence receive Board Paid benefits. Our medical consultant may contact you to discuss the diagnosis and confinement period.

- **FOR ILLNESS OF EMPLOYEE:**

  1. Diagnosis: Please provide required ICD Code and description for each medical condition:

     ICD Code: _____ Description: _____

     ICD Code: _____ Description: _____

  2. Recommend leave of absence from _____ to _____
     Date (be specific) Date (be specific)

- **FOR ILLNESS OF FAMILY MEMBER:** _____
  Relationship to Miami Dade School Board Employee (must be accompanied by FM-7497)

  _____ is a patient of mine and needs to be cared for by your employee.
  Patient Name/Date of Birth

  1. Diagnosis: Please provide required ICD Code and description for each medical condition:

     ICD Code: _____ Description: _____

     ICD Code: _____ Description: _____

  2. Recommend leave of absence from _____ to _____
     Date (be specific) Date (be specific)

- **FOR PARENTAL LEAVE:** Estimated date of Confinement (EDC) _____

_____ _____ _____
Physician's Name Printed Physician's Signature Date

_____ _____
Specialty Phone Number

FM-6030 Rev. (03-17)

MDCPS LEAVE OFFICE FAX: 305-523-0495