



MIAMI-DADE COUNTY PUBLIC SCHOOLS
LEAVE OF ABSENCE MEDICAL DOCUMENTATION

TO: _____ (Physician/Health Care Provider)
(Please Print)

_____ has applied for an extended leave of absence. Please
(Employee Name/Employee Number)

provide the following information:

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 ILLNESS OF EMPLOYEE:**

1. Diagnosis:

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

ICD Code: _____ Description: _____

ICD Code: _____ Description: _____

ICD Code: _____ Description: _____

2. Recommend leave of absence from _____ to _____ based on
(Date) *(Date)*
patient's medical condition.

● **FOR ILLNESS OF FAMILY MEMBER:**

_____ is a patient of mine and needs to be cared for by
(Patient Name)

your employee _____ from _____ to _____
(Employee Name) *(Date)* *(Date)*

Diagnosis:

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

ICD Code: _____ Description: _____

ICD Code: _____ Description: _____

ICD Code: _____ Description: _____

● **FOR PARENTAL LEAVE:**

Estimated Date of Confinement (EDC) _____

Physician's Name Printed

Physician's Signature

Date

Phone

Specialty