G-3132 © GCCG-EB
PROFESSIONAL / SUPPORT STAFF VOLUNTARY TRANSFER OF ACCRUED ANNUAL OR STRAIGHT LEAVE EMPLOYEE TRANSFER LEAVE PROGRAM STATEMENT OF HEALTH CARE PROFESSIONAL

After completing this form, please send to:

CISD Superintendent
PO Box 70
Cuba NM 87013

Name of Patient _____
Last First MI
If the patient is not an employee of the District above
what is the relationship to the employee _____

Please answer the following questions (attach additional pages if necessary):

1. Describe the nature of the illness/injury (diagnosis) _____

2. State the approximate date the illness/injury commenced, and the probable duration of the illness/injury (and also the probable duration of the patient's present incapacity, if different). _____

3. Will it be necessary for the patient to be on an intermittent or a less than full schedule as a result of the illness/injury (including for treatment described in item 6 below)?
Yes _____ No _____
If yes, give the estimated date of return to full-time work or a normal schedule. _____

4. If the patient will be absent from a full schedule because of treatment of the illness/injury on an intermittent or part-time basis, provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any.
_____

5. If any of these treatments will be provided by another provider of health services (e.g. physical therapist), please state the nature of the treatments. _____

6. Is it necessary for the patient to be absent from work for treatment? Yes _____ No _____

7. What is the date you first required the patient to begin treatment for the illness or injury? _____

This is to certify that this patient has suffered a medical condition that will require the patient to take a prolonged absence from performing his/her normal duties or in the alternative requires a family member of the patient as care taker to take a prolonged absence from their duties to assist in the care of the patient during treatment and recovery.

_____ _____
Health Care Provider Signature Name (please print)

_____ _____
Date Street or Box Address City State ZIP

Telephone Number _____