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When completed, this form should be returned to the employee ~~NOT~~ the Jackson Public School District

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6. Is the employee unable to perform his/her job? (Employee should supply you with information about his or her job.)

7. Description of Care Needed:

- a. If leave is required to care for an immediate family member (spouse, parent, step ~~parent~~, child, or step child) of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?
  
- b. If the patient will need care only intermittently or on a ~~part~~ basis, please indicate the probable duration of this need:

Signature of Health Care Provider

Printed Name of Health Care Provider

Type of Practice

Address

Telephone Number

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule