

**Physician's Statement Regarding Continued Disability Related
to Pregnancy, Childbirth, or Miscarriage**

NOTE: This form is only to used when a request is being made for an extension of the thirty days normally allowed following pregnancy, childbirth, or miscarriage. Eagle County School District policy requires that if the disability continues and the staff member is requesting sick leave, this form must be completed on a weekly basis. A copy of the complete sick leave policy is included for the physician's reference.

Patient's Name: _____ Date: _____

This is to certify that the above patient is still temporarily disabled as a result of pregnancy/childbirth/miscarriage (circle one) and is unable to perform her normal work duties. It is my professional opinion that this disability will continue commencing _____ and ending on _____ (not to exceed 7 calendar days).

Please include a brief statement as to why this person's disability has continued beyond the normally allowed thirty days, which was caused or contributed to by pregnancy, childbirth, or miscarriage:

Physician's Name Date

Physician's Signature Date

Physician's Address

Physician's Phone Number

Patient's Signature Date

I would like to activate the sick leave bank if I meet the requirements to do so as defined in Policy GCCAAA, *Volunteer Sick Leave Bank*. (Please initial)