Human Resources Department
3900 Broadway Avenue
Everett, WA 98201
425-385-4115
Benefits Fax Number: 425-385-4135

MEDICAL DOCUMENTATION
EVERETT PUBLIC SCHOOLS SHARED LEAVE PROGRAM
Return to Human Resources

I hereby authorize you to release the information requested to Everett Public Schools.

_____ _____
(Employee signature) (Date)

To the physician or authorized health care practitioner of _____
(Print name of employee, relative or household member)

_____ , an employee with Everett Public Schools, has applied for shared leave donations from other employees of Everett Public Schools under the district's shared leave program. In order to receive shared leave, state law requires that the health condition causing the employee to apply for shared leave must be verified by a licensed physician or other authorized health care practitioner as an illness, injury, impairment, or physical or mental condition that is of an ***extraordinary, severe or life-threatening nature***. Please provide a short description of the health condition of the individual named above.

_____

_____

_____

Expected duration of this condition: _____

Can you verify that this is a condition of: ***extraordinary, severe or life threatening nature?***

☐ **Yes**

☐ **No**

Signature: _____ Date: _____
(Signature of health care provider)

Name: _____
(Print name of health care provider)

Address: _____