

MEDICAL CERTIFICATION COVID-19 TEMPORARY TELEWORK REQUEST

Return this form via Fax: 225-218-4020 Email: medcert@ebrschools.org (Subject Line: Employee's Name)

| This section to be completed by the EMPLOYEE | |
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| DATE: EM | IPLOYEE'S NAME: |
| WORK LOCATION: | EMP # OR SOCIAL: |
| POSITION: | EMAIL: |
| CONTACT PHONE: | |
| TELEWORK REQUESTED: ☐ Yes☐ No | □ Uncertain PATIENT: □ Self □ Family Member |
| Name of Patient | Relationship |
| | and verbal information to the East Baton Rouge Parish School System regarding myself or migibility for employee leave. I understand that I must have written clearance from the below earing me to return to work after treatment. |
| Employee's Signature: | Date: |
| PATIENT'S NAME: | PROVIDER — Please fill out the information below fully and completely, all applicable parts. □ Employee □ Family Member |
| 2. Is the employee able to perform work of3. Is the condition considered catastrophic i | nployee/patient to TEMPORARILY TELEWORK? |
| TELEWORK IS NOT GUARANTEED TO BE A | A PERMANENT OPTION. |
| · · · · · · · · · · · · · · · · · · · | related to the condition for which the employee seeks to TEMPORARIALY vorkplace (such medical facts may include symptoms, diagnosis, or any use of specialized equipment): |
| | |
| Physician's Name: | Address: |
| Professional License Number: | Issuing State: |
| Phone Number: | Email Address: |
| Physician's Signature: | Date: |

This form can be mailed to: EBRPSS Office of Human Resources P.O. Box 2950 Baton Rouge, LA 70821-2950