PM 11
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Louisiana Department of Social Services
Office of Family Support

# Leave With/Without Pay Physician's Statement

_____
Date

Cost Center Name: _____

Cost Center Address: _____

_____

_____

Employee Name: _____

Signature: _____

SSN: _____

Address: _____

_____

_____

_____

Patient's Name (if different from above) _____

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The above named person, who is an employee of this Agency, has requested a leave of absence for

_____

purposes. The employee's signature authorizes the release of his/her medical information. We request the following information to allow our Agency to make a decision on the employee's request for leave:

Diagnosis: _____

Last day of work: _____

Anticipated date of incapacitation, if different from above: _____

Date employee may return to work: _____

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Physician's name: _____

Physician's address: _____

_____

_____

_____

Physician's Signature _____

Date _____

Necessary attachments are affixed.

Please mail completed form to the Cost Center address shown above or return to employee for handling.