DA 325 (Revised 3-08)

STATE OF KANSAS
SHARED LEAVE PROGRAM
Shared Leave Request Form

When completing forms please write legibly and be clear and thorough with explanations.

Employee Name _____ Employee ID# _____

PART II – Licensed Healthcare provider Statement

Patient's Name _____

Date first consulted for this condition _____

Describe the **nature** of the illness, injury, impairment or physical or mental condition (please attach documentation):
_____
_____
_____

Describe the **diagnosis** of the illness, injury, impairment or physical or mental condition (please attach documentation):
_____
_____
_____

Describe the **treatment and prognosis** of the illness, injury, impairment or physical or mental condition (please attach documentation):
_____
_____
_____
_____

Anticipated duration the patient will be unable to work due to the condition: From _____ Through _____

Dates of hospitalization (if applicable): From _____ Through _____

Date of Surgery (if applicable): _____

Physician Name _____ Telephone Number _____

Address_____

_____
City State Zip

Licensed Health Care provider Signature _____ Date _____