NEVADA SYSTEM OF HIGHER EDUCATION
REQUEST FOR EXTENDED SALARIED SICK LEAVE
MEDICAL CERTIFICATION

Employee Name: ___________________________ Employee ID# _____________________

I am requesting Extended Salaried Sick Leave from my employer, and under the provisions of the Board of Regents Code, my employer requires that I submit medical certification that I am unable to perform or resume my duties. Please answer the questions listed below so that I can complete my request.

___________________________________________  _______________________
Employee Signature       Date

PHYSICIAN NAME: ___________________________________________________________

TYPE OF PRACTICE: __________________________________________________________

ADDRESS: ___________________________________________________________________

PHONE NUMBER: ____________________________________________________________

Approximate Date condition commenced: _______________________________________

Probably duration of condition: _______________________________________________

Is the employee unable to perform any of his/her job functions due to the condition: ___ Yes ___ No

Describe the medical facts which support your certification that the employee is unable to resume their duties (this may include symptoms, diagnosis, or any treatment regimen):

____________________________________________________________________   _______________________
Signature of Health Care Provider       Date

Revised October 1, 2017