TO BE COMPLETED BY PHYSICIAN

Compassionate Care Leave - Physician's Certification Form

City of Dallas

All information included on this form will be confidential and will not be released by the City of Dallas or without the written consent of the employee.

Applicant Information

Employee Name (First Last): _____

Employee Number: _____

Address: _____

_____

Employee Contact Number: _____

Alternative Contact Number: _____

Authorization to release information: I hereby authorize the undersigned physician to release information acquired in the course of my treatment to the City of Dallas for Compassionate Care Leave Program eligibility determination. I understand that this authorization to disclose information will expire three hundred and sixty-five (365) days from the date that appears next to my signature or upon receipt by the certifying physician of my written revocation, whichever comes first.

_____ _____

Employee/Patient Signature (or Legal Representative) Date

To Be Completed by Patient's Physician

This section applies to the patient's medical condition in support of the request or consideration for the City of Dallas Compassionate Care Leave Program. A letter from the physician containing this information may be attached.

1) Patient history and diagnosis

2) Continued Required Treatment for Illness/Injury

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3) Prognosis (please include ability and timeframe to return to work)

Clinic or Practice Name: _____

Address: _____

_____

Contact Number: _____

Fax Number: _____

Email: _____

Physician's Name: _____

Physician's Signature: _____

Date Signed: _____