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.

Employee/Patient Information			
Patient Name:		**City of Dallas ID #:**	
Home Address:		**Contact #:**	
		Alternate Contact #:	

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:**

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

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4. When will the employee be able to return to work? _____

Clinic/Practice Information			
Clinic or Practice Name:		**Email Address:**	
Address:		**Phone #:**	
		Fax #:	
Physician's Name:			

_____ _____

Physician's Signature **Date Signed**