CITY OF LITTLE ROCK – CATASTROPHIC LEAVE REQUEST PHYSICIAN CERTIFICATION FORM

Return completed form to Fax (501) 371-4496, Attention: Keisha Walker
Please call (501) 371-4526 if you have any questions regarding completion of this form.

EMPLOYEE NAME: _____

DATE EMPLOYEE WILL EXHAUST PAID LEAVE BALANCES: _____

Authorization to Release Information: I hereby authorize the undersigned physician to release information acquired in the course of my examination or treatment to the City of Little Rock's Catastrophic Leave Bank Committee for eligibility determination for short-term salary continuation. I understand that this authorization to disclose information will expire thirty (30) days after the date of my signature or upon receipt by the physician of my written revocation, whichever comes first.

_____ _____
Employee Signature (or Legal Representative's Signature*) Date

_____ _____
*Printed Name of Employee's Legal Representative Relation to Employee

TO BE COMPLETED BY PATIENT'S PHYSICIAN

1) HISTORY:

a) When did the patient first seek treatment for this illness/injury/condition? _____

2) DIAGNOSIS:

a) Provide a brief narrative of the nature and extent of the present injury/illness/condition which is creating the need for short-term salary continuation provided by the City of Little Rock's Catastrophic Leave Bank Program:

_____

_____

_____

3) REQUIRED TREATMENT FOR THIS ILLNESS/INJURY/CONDITION:

a) When did you last examine the patient for this illness/injury/condition? _____

b) Give a brief description of the frequency of continuing treatments required by this condition:

_____

_____

_____

4) PROGNOSIS AND ANTICIPATED TIME DURATION THAT EMPLOYEE WILL BE UNABLE TO WORK DUE TO THE HEALTH CONDITION:

a) If there are no further complications, what is the minimum recovery time before the employee may return to work?

Approximate Return to Work Date: _____

b) What is the maximum recovery time of the patient before the employee may return to work?

Approximate Return to Work Date: _____

c) Is there a possibility of returning to work on an intermittent or reduced schedule? □ Yes □ No

If yes, please explain when the employee might return to work on a modified schedule and specify any limitations or reasonable accommodations the employee may need:

_____

_____

_____

_____

This medical certification will be used by the City of Little Rock's Catastrophic Leave Bank Committee to determine if the employee meets the eligibility criteria for a short-term salary continuation after exhausting leave benefits due to this illness/injury/condition. If the duration of this medical condition continues beyond thirty (30) days, your patient will need you to complete this form again to request additional Catastrophic Leave benefits.

_____ _____
Clinic Name Clinic Phone Number

_____
Clinic Address

_____
Printed Name of Physician

_____ _____
Signature of Physician Date

Note: The employee is responsible for the completion of this form at his own expense. All information listed on this form will be kept confidential and will not be released by the City of Little Rock without written consent of the employee or the employee's legal representative.