CERTIFICATION OF HEALTH CARE PROVIDER

Health Care Provider means a doctor of medicine or osteopathy, podiatrist, dentist, clinical psychologist, optometrist, or chiropractor legally authorized to practice under state law.

Health Care Provider's Name:	Telephone Number: ( )
Health Care Provider's Group Name:	Address:

Employee Name:_____ Employee ID#:_____

MEDICAL/LEGAL RELEASE AUTHORIZATION

As evidenced by my signature below, you are authorized to provide my employer with information concerning: 1) my medical or dental care and treatment, or 2) treatment of the medical or dental care and treatment of my immediate family.

_____ Date: _____

Employee or Designee's Signature

Designee's Relationship:_____ Phone:_____

EMPLOYEE'S PERSONAL HEALTH CARE

Date Condition Commenced: _____Probable Duration or * Ending Date: _____

***If the ending date is undetermined, new documentation must be submitted every six (6) weeks following the commencement date.**

Describe the health condition which makes the employee unable to perform the essential functions of his/her position. Attach additional page(s) if necessary.

_____
_____
_____

HEALTH CARE OF FAMILY MEMBER

Name/Relationship _____

Date(s) Employee's presence necessary for care of family member:

Beginning Date: _____ Probable Duration or * Ending Date: _____

***If the ending date is undetermined, new documentation must be submitted every six (6) weeks following the commencement date.**

Describe the health condition of family member which requires the employee's presence. Attach additional page(s) if necessary.

_____
_____
_____

_____ _____

Signature of Health Care Provider (no stamps) Date

This form must be completed in its entirety or solicitation package will be returned.

Retention Schedule: Upon completion, this form shall be retained permanently in the Recipient's Leave Donation File in Correctional Human Resources Management and in the local medical File.