COUNTY OF YOLO
Catastrophic Leave Bank Program

PHYSICIAN'S CERTIFICATION

Employee Name

(Print or type) Last First Middle

Address

Street City/State Zip

Patient Name

(Print or type) Last First Middle Relationship to Employee

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release information acquired in the course of my examination or treatment to the County of Yolo Catastrophic Leave Bank Program Committee for eligibility determination purposes for Catastrophic Leave Bank benefits. 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.

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

(Date) Patient's Signature or Legal Representative (If Different than Employee)

THE EMPLOYEE AND/OR PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM AT HIS OR HER OWN EXPENSE

(To be completed by the Patient's Physician)
Please Print or Type

THE FOLLOWING QUESTIONS APPLY ONLY TO THE MEDICALCONDITION RELATED TO THE PATIENT'S APPLICATION FOR LEAVE BENEFITS FROM THE COUNTY OF YOLO CATASTROPHIC LEAVE BANK PROGRAM

For purposes of the County of Yolo Catastrophic Leave Bank Program, a medical condition means a catastrophic and debilitating medical situation, terminal illness, or severely complicated disability and/or severe accident of the employee or qualifying family member that causes the employee to be unable to perform his/her job, requires a prolonged period of recuperation or intermittent treatment (i.e. chemotherapy, radiation therapy, etc.), and/or requires the employee's absence for duty.

1. **HISTORY**

(a) When did patient first seek treatment for this illness/injury? Mo. _____ Day _____ Year _____

(b) Could this illness/injury be work related? Yes ☐ No ☐

(c) To your knowledge has patient ever had the same or similar condition? Yes ☐ No ☐
If "Yes," state when and describe:

2. **PRESENT CONDITION:**

(a) Is surgery: Required? ☐ Elective? ☐ Date of Surgery: _____

When was the patient informed by the attending physician? Mo. _____ Day _____ Year _____

(b) Is patient? (Check one) ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized

3. **DIAGNOSIS:** Give a brief narrative of the nature and extent of the present illness/injury which is creating the need for assistance through the County of Yolo Catastrophic Leave Bank Program. Only that information which supports the employee's need for catastrophic leave should be provided.

4. **CONTINUING REQUIRED TREATMENT FOR THIS ILLNESS/INJURY**

(a) Projected date of first office visit/treatment Mo. _____ Day _____ Year _____

(b) Frequency of visits/treatments Weekly ☐ Monthly ☐ Other _____

(c) When did you last examine the patient? Mo. _____ Day _____ Year _____

(d) Give a brief description of the continuing treatments required by this illness/injury:

5. **ANTICIPATED TIME DURATION THAT EMPLOYEE WILL BE UNABLE TO WORK DUE TO THE HEALTH CONDITION OF THE EMPLOYEE OR REQUIRED DIRECT CARE OF A FAMILY MEMBER**

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

_____

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

_____

(c) Is there a possibility of working an intermittent or reduced schedule or returning to work on a part-time basis with job duties altered, within reason, to better fit the employee's needs?

Yes ☐ No ☐ Approximate Return Date: _____
Please explain any limitations:

_____

_____

_____
Signature of Attending Physician

_____
Clinic Name

_____
Address

_____ | _____
Telephone Date