



Office of Personnel Management
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 my employer's Catastrophic Leave Bank Program Committee for eligibility determination purposes for short-term disability 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 ALL INFORMATION LISTED ON THIS FORM WILL BE KEPT CONFIDENTIAL AND IS NOT TO BE RELEASED BY THE EMPLOYER WITHOUT WRITTEN CONSENT OF THE EMPLOYEE

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

THE FOLLOWING QUESTIONS APPLY ONLY TO THE CONDITIONS RELATED TO THE PATIENT'S APPLICATION FOR SHORT-TERM DISABILITY BENEFITS FROM THE STATE OF ARKANSAS CATASTROPHIC LEAVE BANK PROGRAM

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 short-term disability provided by the State of Arkansas Catastrophic Leave Bank Program:

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. **PROGNOSIS AND 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?
Approximate Return Date: _____
- (b) What is the maximum recovery time of the patient before the employee may return to work?
Approximate Return Date: _____
- (c) If the patient is a State Employee, 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 his/her needs?
Yes No If yes, Approximate Return Date: _____
Please explain any limitations: _____

Clinic Name	Signature of Attending Physician
Address	
Telephone	Date