

ARKANSAS FORESTRY COMMISSION
CATASTROPHIC LEAVE BANK PROGRAM
PHYSICIAN'S CERTIFICATION FOR CATASTROPHIC LEAVE

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 any and all information acquired in the course of my examination or treatment for the purpose of consideration by the Catastrophic Leave Committee.

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

(Date) Patient's Signature or Legal Representation
(If different that Employee)

THE EMPLOYEE AND/OR PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM AT HIS/HER OWN EXPENSE. ALL INFORMATION LISTED ON THIS FORM WILL BE KEPT CONFIDENTIAL.

(To be Completed by the Attending Physician)
Please Print or Type

THE FOLLOWING QUESTIONS APPLY ONLY TO THIS ILLNESS/INJURY

1. HISTORY

a) When did patient first seek treatment for this illness/injury? Mo. ____ Day ____ 20 ____

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

c) To your knowledge has patient ever had 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 this patient informed by the attending physician? Mo. ____ Day ____ 20 ____

b) Is patient? (Check One) ____ Ambulatory ____ House Confined ____ Bed Confined ____ Hospitalized

- c) Give a brief narrative of the nature and extent of the illness/injury:

3. DIAGNOSIS

4. TREATMENT FOR THIS ILLNESS/INJURY

- a) Date of first visit? Mo. ____ Day ____ 20____
b) Frequency of visits? Weekly ____ Monthly ____ Other ____
c) When did you last examine the patient? Mo. ____ Day ____ 20____
d) Give a brief description of the treatment:

5. PROGNOSIS AND ANTICIPATED DURATION EMPLOYEE WILL BE UNABLE TO WORK DUE TO A CONDITION OF THE EMPLOYEE OR 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, would there be the possibility of 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 limitations.

ADDITIONAL DOCUMENTATION MAY BE ATTACHED

Clinic Name

Signature of Attending Physician

Address

Date

Telephone