EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM
MEDICAL REQUEST FORM

TO BE COMPLETED BY EMPLOYEE'S TREATING PHYSICIAN

PATIENT'S NAME: _____

DIAGNOSIS(ES): _____

_____

ICD CODE(S): _____ _____ _____ _____

SUMMARY OF TREATMENT(S) & PROCEDURE(S): _____

_____

_____

_____

CPT CODE(S): _____ _____ _____ _____

SURGERY DATE (IF APPLICABLE): _____

HOSPITALIZATION DATE(S) (IF APPLICABLE): From: _____ **To:** _____

CAN EMPLOYEE WORK IN A MODIFIED CAPACITY? YES_____ **NO**_____

IF YES, EXPLAIN RESTRICTIONS FOR MODIFIED DUTY:

_____

_____

DATE EMPLOYEE IS LIKELY TO RETURN TO:

MODIFIED DUTY: _____ **FULL DUTY:** _____

_____ _____

PHYSICIAN'S SIGNATURE **PHYSICIAN'S NAME (PRINTED)**

_____ _____

PHYSICIAN'S PHONE NUMBER **DATE FORM COMPLETED**

This document shall be treated as a confidential medical record; it shall not be placed in the employee's personnel file. Only those individuals with a need to know this information will be given access to it. An employee who fails to appropriately safeguard the confidentiality of this information will be subject to disciplinary action, including termination from State Service.