CATASTROPHIC LEAVE
MEDICAL STATUS FORM

NOTE TO PHYSICIAN: *The purpose of this form is to confirm the necessity for the City of Richardson employee's request to use leave from the catastrophic leave program.*

PLEASE PRINT	
Employee Name:	
Department:	Job Title:
Phone #:	Date:
Physician's Name:	Physician's Address:
Describe the nature of the catastrophic illness or injury ***(to be completed by physician)***	
Date of last Doctor's Visit:___________________ Anticipated date of return to work:______________________ Will intermittent leave be necessary?________ If so, please explain____	
I attest that the information in this document is true and correct and that the need for the requested leave is medically necessary.	
Physician's Signature	Date
I authorize the release of the medical information contained in this form to my employer, The City of Richardson.	
Employee Signature	Date

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