Department of Human Resources
36525 SE Industrial Way
P. O. Box 547, Sandy, OR 97055-0547
(503) 668-5541
(503) 668-7906 fax

Attending Physician's Statement

Note: It is **extremely** important to fully complete this form in order for your petition to be given full consideration.

Section I – TO BE COMPLETED BY EMPLOYEE. Return completed form to the District's Human Resources Department along with your petition.

Please Print or Type

Physician Information	Patient Information
Physician's Name	Employee's Name
Street Address	Patient's Name (if other than employee)
City State Zip Code	Employee Number
Telephone Number Fax Number	Telephone Number

Personal health information on this form is collected under the authority of the Oregon Trail School District's Catastrophic Leave Program, per agreement between OTSD 46, the East County Bargaining Council and the Oregon School Employees Association. It is related directly to and needed to support your petition for benefits under the Catastrophic Leave Program.

Pursuant to the tenets of Protected Health Information (PHI) as delineated in the Health Insurance Portability and Accountability Act (HIPAA), the undersigned employee authorizes and consents to the physician named on this form to disclose to the Oregon Trail School District, health information as is necessary or as may be reasonably required to determine eligibility for the Catastrophic Leave program.

I understand that the District will maintain and store this information in such a manner as to protect its confidentiality.

Signature of Employee or Patient (if other than employee)	Date

Section II – TO BE COMPLETED BY THE ATTENDING PHYSICIAN.

The above named School District employee has petitioned for special consideration on medical grounds. The staff member or the patient related to the staff member is authorizing you, the attending physician, to release the information requested below. Please retain a copy of this form for your files as your office may be contacted to verify that this statement was completed by the attending physician. The original form must be returned to the employee for submission with the catastrophic leave petition.

Please Print

1. Date you received this form:

_____

2. Consultation Date(s):

_____

3. Dates of illness/accident: Start: _____ End: _____

4. Summary of Nature of illness/accident:

_____

_____

_____

_____

5. Do you think the illness/accident and/or treatment prescribed **seriously** affects the employee's ability to perform his/her work functions? (circle one) **Yes** or **No**

6. If yes:

a) In what way?

_____

_____

b) During what period of time?

_____

7. When will the patient be able to resume his/her duties?

_____

8. Do you have any further comments regarding this patient's condition as it relates to his/her petition?

_____

_____

_____

Physician's Signature	Physician's Stamp
Date	

For Office Use Only
Verified By: _____ Date: _____

If you have any questions about the collection of personal information by the Oregon Trail School District, please contact the Human Resources Department at (503) 668-7450.