San Bernardino County

MEDICAL EMERGENCY LEAVE (MEL)

ATTENDING PHYSICIAN'S STATEMENT

Please Mail or Fax Completed Form To:

San Bernardino County
Employee Benefits and Services - Leaves Team
157 W. 5th Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5787 / (909) 387-5566 Fax

AUTHORIZATION OF PATIENT (EMPLOYEE)

MUST print in Black or Blue ink ONLY

Employee ID	Employee Name	Home Address, City, State, Zip	Telephone	Date of Birth

I hereby authorize the release if any information requested in respect to this application to San Bernardino County.

Signature	Date

Note: The patient is responsible for the securing of this form and any charge that may be required for its completion

ATTENDING PHYSICIAN'S STATEMENT

TO PHYSICIAN - PLEASE NOTE:
The benefits being applied for by your patient do not cover hospitalization, surgical, medical or professional charges. No fees for the completion of this form are chargeable to the San Bernardino County.

This form may be mailed or faxed directly to address/fax number listed above or given directly to the patient at the physician's discretion.

Patient Name	Date of Birth

1. HISTORY

a) When did the symptoms first appear or accident happen? _____

b) Is Disability:

☐ Total (*Employee is unable to work in any capacity*)

☐ Partial (*Employee is able to work in a modified capacity or a reduced work schedule*)

If disability is partial state work duty or hour restrictions:

Work Duty Restrictions	Hour Restrictions

c) Date disability commenced: _____

d) Has patient ever had the same or a similar condition? ☐ Unknown ☐ No ☐ Yes - *State when and describe*

_____

e) Is condition due to injury or illness arising out of patient's employment? ☐ Unknown ☐ No ☐ Yes

f) Name(s) of any other treating physicians: _____

2. DIAGNOSIS WITH ICD-10 CODES

a) Primary: _____

b) Secondary (*if applicable*): _____

c) Objective Findings (*including results of current x-rays, EKG's, or any other special tests*):

_____

_____

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ATTENDING PHYSICIAN'S STATEMENT (CONTINUED)

PATIENT NAME: _____

3. PLAN OF CARE (Describe Treatments, Therapies, Medications and their Durations)

_____

_____

_____

4. PREGNANCY (*if applicable*)

Is this patient now pregnant or has she been pregnant since the date of treatment as reported above?

☐ No ☐ Yes If Yes, date pregnancy terminated or future EDC: _____

Is pregnancy normal?

☐ No ☐ Yes If No, state the abnormal and involuntary complication causing maternal disability:

_____

5. SURGERY (*if applicable*)

If patient has had or is scheduled to have a surgical procedure, enter date of surgery: _____

Type of surgery: _____

6. ESTIMATED RETURN TO WORK DATE

Based on your examination of patient, disability should end or will end sufficiently to permit the patient to resume regular and customary work or temporary transitional work:

Estimated Return To Work Date: _____ ☐ Temporary Transitional Work ☐ Regular & Customary Work

7. Have you reported this or a concurrent disability to any insurance carrier as a Workers' Compensation Claim or to any other disability insurance provider?

☐ No ☐ Yes Name of carrier or firm: _____

8. HOSPITALIZATION (*for this disability*)

a) Was/is patient admitted as a registered bed patient in a hospital? ☐ No ☐ Yes

b) Was patient treated in the surgical unit of a hospital or other surgical unit? ☐ No ☐ Yes

If yes to (a) or (b), provide name and address of hospital or surgical unit: _____

_____

Date and hour admitted as a registered bed patient and discharged from hospital:

Date Admitted _____ at _____ a.m./p.m.

Date Discharged _____ at _____ a.m./p.m.

I certify that, based on my examination, the above statements truly describe the patient's disability (if any) and the estimated duration thereof, and that I am a _____ licensed to practice in the State of _____.

(*TYPE OF PHYSICIAN*)

Practice Specialty (i.e., Psychiatry, Family Practice, General Practice, etc.): _____

Physician's Name as shown on License (Print or Type)	**State License Number**		**Telephone**
Mailing Address	**City**	**State**	**Zip**
Signature of Attending Physician			**Date**