EMPLOYEE MEDICAL CERTIFICATION RELEASE FORM

In order to fairly assess your situation, we need to gather additional information. The Human Resource Office requires the ability to communicate with your health care provider to obtain specific information.

Please sign the Authorization to Release Information below giving your Health Care Provider permission to release information to the Dallas County Community College District Human Resource Office.

Employee Complete This Section (Please Print or Type):

Name: _____
(Last) (First) (Middle Initial)

Social Security Number: _____

Home Address (Street, City, State, and Zip):

Home Phone #: _____E-Mail: _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize the Human Resource Office at the Dallas County Community College District Office to receive information from the provider below. I understand the reason for this medical certification is to determine my eligibility for medical leave under state and/or federal regulations, and/or applicable college policy.

Name of Provider:

Address (Street, City, State, and Zip):

Phone Number: _____

Expiration Date of Authorization: _____ (indicate date, or an event relating to you or to the purpose of the authorization).

Employee's Signature: _____ Date: _____