Medical Emergency Certification

To Certify a Medical Emergency by a Physician

100 Northside Square Huntsville, AL 35801 *Fax: 256-532-3322*

TO BE COMPLETED BY EMPLOYEE	
Employee Name:	**Patient Name:**

I hereby authorize the physician named below to disclose to Madison County Commission protected medical information for the purpose of determining eligibility to utilize Sick Leave Bank benefits designated for medical emergencies and catastrophic illnesses and understand I may revoke this authorization in writing at any time.

Employee Signature: _____ Date: _____

Patient or Guardian Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN	
Physician Name:	**Physician Practice:**
Type of Practice:	**Phone Number:**
Practice Address: _____ (Address) _____ (City) _____ (State) _____ (ZIP)	
Describe the medical facts which support the certification of a medical emergency or catastrophic illness.	
Date Emergency Began:	**Anticipated Date Emergency Ends:**
If the patient is not the employee, what assistance will be required to attend to the needs of the patient?	

I hereby certify that the individual listed above is a patient of mine and is suffering from a medical condition which will cause the patient or employee (due to caretaking responsibilities) to be absent from work for an extended period of time.

Physician Signature: _____ Date: _____