ROUND ROCK TEXAS
HUMAN RESOURCES

CATASTROPHIC LEAVE
HEALTHCARE PROVIDER STATEMENT

Patient Release (Part A to be completed by patient)	
PART A	I authorize my HealthCare Provider to release any information requested on this form and any other pertinent information concerning my condition to the City of Round Rock Human Resources Department.

Name of HealthCare Provider:

Patient Signature: **Date:**

Patient Name (Print):

Select One: ☐ **City of Round Rock** (CORR) **Employee** ☐ **Immediate Family Member of CORR Employee**

Healthcare Provider Information (Part B to be completed by Healthcare Provider)	
PART B	The information requested is solely for the purpose of determining the eligibility for catastrophic leave benefits and the amount of time needed by the City of Round Rock employee to meet the needs of this condition.

1. Is the treatment or procedure medically necessary?	☐ Yes	☐ No
2. Diagnosis of Condition or Injury:		
3. Is the treatment or procedure urgent? (Does the patient have a choice of if or when this treatment or procedure is done?)	☐ Yes	☐ No
4. Would the condition result in death if not treated timely	☐ Yes	☐ No
5. Is or was hospitalization for more than 72 consecutive hours required for this condition?	☐ Yes	☐ No
6. Is this condition considered a terminal illness?	☐ Yes	☐ No

7. If the patient is NOT the City of Round Rock employee: is the City employee's presence necessary for basic medical hygiene, nutritional needs, safety, and/or transportation? This may include psychological comfort.

If yes, please provide the following information:

☐ The patient will need continual assistance. Indicate duration if known.

☐ The patient will need intermittent assistance. State kinds of support and care that will be needed including schedule and duration if known.

☐ Other (Continue on back if necessary)

8. Regimen of treatment to be prescribed. Indicate number of visits, general nature and duration of treatment, including referral to other healthcare providers. (Continue on back or additional sheets if necessary)

Signature of HealthCare Provider: **Date:**

Name of Health Care Provider (Print): **Phone:**

Type of Practice (Field of Specialization, if any):

Original to HR; copy to employee