PHYSICIAN RELEASE

Chicago Police Department
Bureau of Administration
Human Resources Division/Medical Services Section Date:_____

Dear Doctor_____:

Re:_____ Employee #:_____ Date of Birth:_____

Your name has been submitted by the police officer listed above as the treating physician managing his/her condition. In order for the Chicago Police Department's Medical Services Section to certify this officer's medical absence or limited duty status, **a report is required on your letterhead, signed and dated by you. Please include all of the following information:**

1. Current diagnosis, including signs and symptoms, preventing this officer's return to work at this time.

2. Date and type of current treatment, including medications, and prognosis.

3. Results of all recent diagnostic tests, office visit notes, and operative reports.

4. A list of work restrictions including the estimated duration of restrictions. Include cardiac clearance if applicable.

Please forward records to: Chicago Police Department
Medical Services Section
3510 S. Michigan Avenue
Chicago, IL. 60653 Attn. Case Manager:_____
FAX: 312-745-_____

Dear Officer:

Department Directives require that the use of the medical roll be certified by the Medical Services Section. Your use of the medical roll or medical programs such as Limited Duty is certified only when you provide the above information to the Medical Services Section.

I hereby authorize the above physician or treatment facility to release any and all information pertaining to my medical history, examinations, medications, prognosis, and/or copies of my records to the Medical Services Section.

MEMBER SIGNATURE:_____ **DATE:**_____

WITNESS SIGNATURE:_____ **DATE:**_____
