6801 Dan Danciger Fort Worth, Texas 76133
Phone: 817-294-0350 Fax: 817-294-0350

Medical Leave of Absence Certification/ Release Form

Patient's Name: _____ Date of Birth: _____ Social Security # : _____

I request and authorize the following:

Name: Medical Provider: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone # : _____

to release information of the patient named above:

Name: Southwest Christian School Attn: Human Resources Department

Address: 6801 Dan Danciger

City: Fort Worth State: Texas Zip: 76123 Phone # : _____

Describe the medical facts which support your certification:

This request and authorization applies to: Starting, Continuing and Ending Dates of Employee's Disability.

☐ Anticipated Starting Date: _____

☐ Release to Return to Work Date: _____

☐ Other/Continuing : _____

_____

Patient Signature: _____ Date Signed: _____

Physician Signature: _____ Date Signed: _____