

CITY OF MILWAUKEE  
APPLICATION FOR ACCRUED TIME OFF DONOR PROGRAM

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_, hereby request authorization to participate in the Accrued Time Off Donor Program established by Common Council File No. 932015, due to a terminal or major catastrophic illness as certified below. I authorize my treating physician to fill out the Physician's Statement indicated below. I understand that the City of Milwaukee reserves the right to require me to obtain, at my own expense, if not covered by the health insurance provider, a second opinion from a physician of my choice as to the nature of the physician's diagnosis and prognosis contained in the physician's statement.

I certify that I have read and understand the procedures outlined under the "Accrued Time Off Donor Program."

Date: \_\_\_\_\_  
Employee Signature

Employee ID.: \_\_\_\_\_ Pension No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

PHYSICIAN'S STATEMENT

This is to certify that (employee) \_\_\_\_\_ has been under my professional care since \_\_\_\_\_. It is my medical opinion that he/she has a life threatening, terminal or medical condition likely to result in a substantial permanent disability within the next year. The diagnosis and prognosis for this condition is:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature Date

Physician's name, address and telephone number:

\_\_\_\_\_  
Department of Employee Relations: Approved Denied

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

The original of the completed form is to be sent to the Department of Employee Relations, Room 706, City Hall, 200 East Wells Street, Milwaukee WI 53202. Employees will be notified of the status of their request by return mail.