HARDSHIP TRANSFER
MEDICAL VERIFICATION FORM

(Physician will complete this form)

An employee has requested a hardship transfer to manage their own serious health condition or care for a seriously ill family member. The information provided will assist in determining the validity of the request and in determining approval status.

Employee's Name: _____

Patient's Name: _____

Patient's Relationship to Employee: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN OR PRACTITIONER

1. Please check the following category that best describes the family member's (patient's) illness.

   ☐ Hospital care
   ☐ Chronic requiring treatment
   ☐ Absence plus treatment
   ☐ Perm or long-term requiring treatment
   ☐ Poses imminent danger of death - Terminal in prognosis
   ☐ Multiple treatments (non-chronic) or requires constant care

   Approximate date condition began: _____ / _____ / _____

   Duration of condition: From _____ / _____ / _____ To _____ / _____ / _____

2. Is the patient presently incapacitated? ("Incapacitated" for these purposes means unable to work or perform other regular daily activities due to a serious health condition including treatment of or recovery from a serious health condition.)

   ☐ Yes – Please indicate an estimated date of recovery, if any: _____ / _____ / _____

   ☐ No

3. Does the patient's illness require a "caregiver" or is it necessary for the Department of Corrections employee to assist the patient with activities that require them to live in close proximity to the patient?

   ☐ Yes – Please describe the type of care the patient requires from the employee:

   _____

   _____

   ☐ No

Physician/Practitioner Signature: _____

Physician/Practitioner Printed Name: _____

Type of Practice/Specialized Field: _____

Telephone Number: _____

Date: / / _____