UNIVERSITY OF MINNESOTA

Route this form to:	U Wide Form UM 1550
Employee Benefits benefits@umn.edu	**Rev:** 11/2021

Vacation Donation Program: Physician's Statement–Confidential Information

Refer to the Administrative Policy: Vacation Donation Program and corresponding Procedures: Requesting/Donating Paid Leave for Civil Service/Labor-Represented Staff. Submit this form with UM 1549: Request to Use the Vacation Donation Program form. Please type or print legibly in ink.

Part One – University of MN Employee Information

Name of University Employee: Patient Name, if different than the employee:	Empl ID:
Date of Birth	

Authorization to Release Information – I hereby authorize the undersigned physician to release any information in the course of my examination or treatment. I understand that any expense incurred in the completion of this form by my physician will be my responsibility.

Patient/University Employee Signature	Date

Part Two – Attending Physician's Statement (Please type or print legibly in ink.)

Date Illness/Injury Began:	Dates Hospitalized (If applicable):
Diagnosis and brief description of illness/injury and concurrent conditions (date of surgery if applicable)	
Anticipated Duration*	
Physician's Name	
Signature	Date

*If an exact date is not known, show a "no sooner than" date.