THE CITY OF NEW YORK Department of Sanitation
MEDICAL NOTES DS 398 (12-95)

NOTE TO EMPLOYEES AND EXAMINING PHYSICIAN: Failure to fill out this form completely may result in denial of medical leave to the patient for the period covered by this medical note.

To Be Completed by Employee	NAME (Last, First — Please Print))(1)	SOCIAL SECURITY NO. (2)	PAYROLL LOCATION (3)	AUTHORIZATION CODE (4)

To Be Completed by Physician

Physician Please Note: (5)
This document is a business record of the City of New York Department of Sanitation, and is essential in the monitoring and control of medical leave.

DATE OF THIS EXAM. (6)	TIME PATIENT ARRIVED AT YOUR OFFICE (7)	TIME PATIENT DEPARTED YOUR OFFICE (8)	OFFICE PHONE NUMBER (Include area code) (9)

PHYSICIAN'S NAME (Please print) (10)	OFFICE ADDRESS (Street, City, State, Zip) (11)

PATIENT COMPLAINS OF: (12)

Do you consider this visit a medical emergency? (13)
❑ No ❑ Yes
(If yes, you must specify nature of medical emergency and Medical Diagnosis below)

MEDICAL DIAGNOSIS (Please include positive findings) (14)

(15)
❑ Patient can travel to DS Clinic on:
(Date) ______________________
❑ Patient can return to work on:
(Date) ______________________

PHYSICIAN'S STATE REGISTRY NUMBER (16)

PHYSICIAN'S SIGNATURE (17)

Mailing Address:
P.O. Box 376
Canal Street Station
New York, NY 10013

To be Completed by Employee

I hereby acknowledge that the above information is true and that all information contained herein has not been altered or changed. I am aware that should this form contain any false information, I may be subject to disciplinary action.

EMPLOYEE'S SIGNATURE (18)

For Clinic Use Only

(19)
❑ Received by Home Visitation Program
❑ Received by Clinic Operations

I have reviewed this document and have the following comments: (20)

DATE

SIGNED BY

REVIEWER'S SIGNATURE