CITY OF OAKLAND

MEDICAL VERIFICATION FORM
CERTIFICATION OF PHYSICIAN OR PRACTITIONER

VERIFIED HIGH RISK FOR SEVERE ILLNESS: COVID-19

EMPLOYEE: Complete the below section before giving this form to your medical provider:

Employee's Name: _____

Employee's Classification: _____

Employee's Department: _____

Employee's Supervisor: _____

HEALTH CARE PROVIDER: Your patient has indicated that they are at higher risk for severe illness from COVID-19 due to an underlying medical condition as described by the Center for Disease Control.[1] The Conditions described by the Center for Disease Control ("CDC") include: (1) chronic lung disease or moderate to severe asthma; (2) serious heart conditions; (3) people who are immunocompromised; (4) severe obesity (BMI of 40 or higher); (5) diabetes; (6) chronic kidney disease, and; (7) liver disease. Considering the conditions listed by the CDC, please complete the below section:

I certify that the above listed employee has an underlying medical condition, as described by the CDC, which makes that employee a higher risk for severe illness from COVID-19.

_____ _____
Signature Date

Physician / Practitioner Name (please print): _____

License#: _____

Address: _____

Phone #: _____ Fax #: _____ Email: _____

EMPLOYEE: Please return this completed form to Risk Management by sending an electronic copy to Erika Turner at ETurner@oaklandca.gov.

[1] *See* https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html