COVID-19 HIGHER RISK PATIENT

Date:_____ Employee Name:_____ DOB:_____

Global ID#:_____ Last 4 of SSN:_____ Phone#:_____

To whom it may concern:

This letter is to confirm that the above patient qualifies as a high-risk patient; as a result, your employee could have medical consequences if exposed to COVID-19.

DIAGNOSIS:_____

EXPECTED RETURN TO WORK DATE:_____

Fax to Ford Medical: 816-459-2053

Email to Ford Medical: kcapmed@ford.com

Ford Medical Phone: 816-459-1237

Printed name of licensed medical provider:_____

Signature of licensed medical provider:_____

Address:_____

Phone#:_____ Date:_____

REVISED & UPDATED FORM 6/23/20