



COUNTY OF HENRICO DEPARTMENT OF SOCIAL SERVICES

P.O. Box 90775  
Henrico, VA 23273-0775  
Fax: (804)501-4006

Ty F Parr  
Director

**Medical Verification**

PATIENT NAME:	PHYSICIAN NAME:
ADDRESS:	ADDRESS:
PHONE:	PHONE:

I, the undersigned, authorize the following information to be given to the Department of Social Services.

_____	_____
Print patient Name	Patient Signature

TO BE COMPLETED BY MEDICAL STAFF ONLY

By signing below, I certify that the patient was in compliance with a physician recommendation to stay home, self-quarantine, or avoid congregating with others during the state of emergency as a result of:

- a) One or more household members was immunocompromised or had a serious health condition; or
- b) One or more household members tested positive for COVID-19 test, or displayed symptoms suspected for COVID-19 and was under the care of a physician.

Indicate duration: \_\_\_\_\_

Start

End

_____	_____
Printed Name of Person completing this form	Title

_____	_____
Signature of Person completing this form	Phone #