

Certification of Physician or Practitioner Catastrophic Leave

Form to be completed by Physician
Employee to complete Items 1 and 9

1. Employee's Name: _____
2. Diagnosis of Catastrophic Illness _____

Catastrophic illness is defined as that of a serious nature, not a passing disorder or temporary ailment, requiring treatment by a physician and hospital admittance. Although some degree of permanency is usually involved, the disease or injury need not necessarily be incurable or permanent. To qualify for the benefits of the program, a catastrophic illness or injury shall result in the employee's temporary or permanent incapacity to perform his or her job function for an extended period of time.):

3. Date condition commenced: _____
4. Probable duration of condition (Specify date): _____

- | YES | NO | |
|------------|-----------|---|
| _____ | _____ | 5. Is inpatient hospitalization of the employee required? |
| _____ | _____ | 6. Is employee able to perform work of any kind?
If "No" skip Item 8. |
| _____ | _____ | 7. Is employee able to perform the functions of employee's position?
(Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.) |

8. If yes, then what is the length of time for which the employee needs to be off work? Please be as specific as possible.

a. Schedule of visits or treatment by Physician or Practitioner:

b. Schedule of visits or treatment by another provider of health services, if referred by Physician or Practitioner:

9. Employee Signature: _____

Date: _____

10. Physician or Practitioner (typed or printed):

Name

Date

11. Type of Practice (field of specialization, if any):

12. Address and Telephone Number of Physician or Practitioner:

Street Address or P.O. Box

City

State

Zip

Telephone

13. Signature of Physician or Practitioner:

Signature