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| **UA-color-left-med** | PMGS 20-02D  July 1, 2020 |

**U of A System Division of Agriculture**

**Catastrophic Leave Bank Program Physician’s Certification**

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| **Part I - (Completed by Employee)** |

Employee Name:

(Print) Last First Middle

Address:

Street City/State Zip

Patient Name:

Last First Middle Relationship to Employee

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the undersigned physician to release any and all information acquired in the course of my examination or treatment for the purpose of consideration by the Catastrophic Leave Committee.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Employee or Legal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Representative (If Different than Employee) Date

**The employee and/or patient is responsible for the completion of this form at his/her own expense. All information listed on this form will be kept confidential.**

**Part II – (Completed by Employee)**

When the employee and patient are the same, the employee is responsible for providing a copy of their most recent job description to the attending physician.

A copy of the employee’s job description is attached.

The patient is not the employee therefore a job description is not attached.

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| **Part III – (Completed by Attending Physician)** |

**NOTE TO PHYSICIAN:** This employee has applied for catastrophic leave under a plan approved by the State of Arkansas. This plan grants paid leave to an eligible employee for self or for the care of an eligible spouse or parent of the employee or of a child of the employee who experiences a ***“debilitating medical situation…severely complicated disability…and severe accident case***…”

When the employee and patient are the same, as indicated in Part II, please review the attached employee’s job description and answer these questions based upon the employee’s description of his/her essential job functions. **The following questions apply only to this illness/injury and all questions MUST BE ANSWERED**.

(A) First date the patient sought treatment for this illness/injury. Month\_\_\_\_\_\_ Day \_\_\_\_\_\_ 20\_\_\_\_

(B) Frequency of visits? Weekly\_\_\_\_\_\_ Monthly \_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(C) When did you last examine the patient? Month\_\_\_\_\_\_ Day \_\_\_\_\_\_ 20\_\_\_\_

(D) First date the patient will be unable to work? Month\_\_\_\_\_\_ Day \_\_\_\_\_\_ 20\_\_\_\_

(E) What is the minimum recovery time for the patient to return to work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Employee Name:

(Print) Last First Middle

(F) What is the maximum recovery time for the patient to return to work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(G) May the patient return to work on a part-time basis? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_

If yes, approximate date the patient will return? Month\_\_\_\_\_\_ Day \_\_\_\_\_\_ 20\_\_\_\_

Please explain limitations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(H) Is surgery: Required? \_\_\_\_\_\_ Elective? \_\_\_\_\_\_

Date of Surgery: Month\_\_\_\_\_\_ Day \_\_\_\_\_\_ 20\_\_\_\_

(I) Is the patient? (Check all that apply)

Ambulatory\_\_\_\_\_\_\_\_\_\_ House Confined \_\_\_\_\_\_ Bed Confined \_\_\_\_\_\_ Hospitalized \_\_\_\_\_\_

(J) Diagnosis (please give diagnosis and a brief narrative of the nature and extent of this illness/injury).

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(K) In your opinion what makes this illness/injury “catastrophic” from a medical standpoint:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(L) Treatment plan (please give a detailed description of the treatment plan): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Employee Name:

(Print) Last First Middle

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| **Part IV– (Completed by Employee if Requesting Leave to Care for Family Member)** |

State the care you will provide and why is it necessary for you to provide this care for your spouse, parent, or dependent child: (Please give detailed information)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician’s Signature (no stamp) Date

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Please return immediately to:

Catastrophic Leave Bank Program

c/o UADA Office of Human Resources

2301 South University Avenue

Little Rock, AR 72204

Or Fax us at: 501-671-2251

Print Name Clinic

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Type of practice / Medical specialty

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