



Case Number: _____

University of Arkansas at Little Rock
Catastrophic Leave Bank Program
Physician Certification Form

PART I – (Completed by Employee)

Employee Name: Last First Middle

Address: Street City/State Zip

Patient Name: Last First Middle

Relationship to Employee: 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 and/or treatment for the purpose of consideration by the Catastrophic Leave Committee.

Employee Signature or Legal Representative Date

Patient's Signature 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 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 or spouse or parent of the employee or of a child of the employee who experiences a personal emergency limited to catastrophic and debilitating medical situations, severely complicated disabilities, and severe accidental injuries. Please help us evaluate this leave request. The following questions apply only to this illness/injury and all questions MUST BE ANSWERED.

- 1. First date the patient sought treatment for this illness/injury. Month Day Year
2. Frequency of visits ? Weekly Monthly Other:
3. First date the patient will be unable to work. Month Day Year
4. Anticipated date the patient will return to work Month Day Year
5. Is surgery: Required Elective Date of Surgery: Month Day Year

If surgery is required, when was the patient informed by the attending physician? Month Day Year

6. Is patient: _____Ambulatory _____House Confined _____Bed Confined _____Hospitalized

7. Could this illness/injury be work related? _____ Yes _____ No

8. When did you last examine the patient? Month_____ Day_____ Year_____

9. Diagnosis (*please give diagnosis and a brief narrative of the nature and extent of this illness/injury*). In your opinion what makes this illness/injury “catastrophic” from a medical standpoint:

10. Treatment plan (*please give a brief description of the treatment plan*):

11. To your knowledge, has this patient ever had the same or similar condition? _____Yes _____No

If yes, state when and describe:_____

Additional documentation may be attached.

Please return to:
Catastrophic Leave Bank Program
c/o UALR Department of Human Resources
Attn: Cynthia Mayhan
2801 S. University Avenue
Little Rock, AR 72204-1099
Fax: 501-569-3181

Physician’s Signature

Date

Physician’s Name (*please print*)

Clinic Name

Address

City

State

Zip

Phone Number

Fax Number