UA LITTLE ROCK | DEPARTMENT OF HUMAN RESOURCES

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
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