

STATE OF IOWA
DEPARTMENT OF ADMINISTRATIVE SERVICES – HUMAN RESOURCES ENTERPRISE
DONATED LEAVE FOR CATASTROPHIC ILLNESS
APPLICATION

Please Print or Type

Part A. TO BE COMPLETED BY THE EMPLOYEE

Name of Employee: Social Security Number:
Department: Payroll Number:
Last Date Worked: Last Date in Pay Status:

Definition – "Catastrophic Illness" means a physical or mental illness, as certified by a licensed physician, that will result in the inability of the employee to work for more than 30 work days on a consecutive or intermittent basis.

Part B. TO BE COMPLETED BY THE PHYSICIAN (FORM WILL BE RETURNED IF NOT FULLY COMPLETED)

- 1. In your opinion, does the employee meet the "Catastrophic Illness" definition above? Yes No (Check one)
If no, sign and date this form. If yes, answer questions 2-8. (If more space is needed, attach an additional sheet.)
2. Diagnosis description:
3. Is condition due to an injury or illness arising from your patient's employment? Yes No (Check one)
4. Method of treatment:
5. Has your patient been hospital confined? Yes No (Check one) Hospital name:
6. On what date was your patient first unable to work?
7. Prognosis:
8. When could employment resume and under what conditions?

Physician's Name (Print):

Physician's Signature: Date:

Address: Street City & State Zip Code

Telephone #: ()

Part C. TO BE COMPLETED BY THE EMPLOYER

The employee has:

- a catastrophic illness based on the physician's statement (above); and
• exhausted all paid leave; and
• been approved for or has exhausted Family and Medical Leave (FMLA); if eligible and
• been approved for medical leave without pay during any hours for which he or she will receive donated leave.

I certify that the employee meets all of the criteria as stated in Section C above.

Employer or Designee Signature Date:

Maintain the original in the employee's confidential personnel file.