Attachment A

STATE OF IOWA
DEPARTMENT OF ADMINISTRATIVE SERVICES – HUMAN RESOURCES ENTERPRISE
DONATED LEAVE FOR CATASTROPHIC ILLNESS
IMMEDIATE FAMILY MEMBER
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:** ____________________

Name of Immediate Family Member: ____________________ **Relationship:** ____________________

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 to attend to an immediate family member 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's immediate family member meet the "Catastrophic Illness" definition above?
   Yes ☐ No ☐ (Check one) If no, sign and date this form. If yes, answer questions 2-5. (If more space is needed, attach an additional sheet.)
2. Diagnosis description: ____________________
   ____
3. Method of treatment: ____________________
4. Has your patient been hospital confined? Yes ☐ No ☐ (Check one) Hospital name: ____________________
   ____
5. Prognosis: ____________________

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:

- an immediate family member with a catastrophic illness based on the physician's statement (above); and
- exhausted all eligible paid leave; and
- been approved for or has exhausted Family and Medical Leave (FMLA); if eligible, and
- been approved for 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.

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