**Part A. TO BE COMPLETED BY THE EMPLOYEE**

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| --- | --- | --- | --- | --- |
| **Name of Employee:** |  |  | **Department:** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Last 4 Digits of SSN:** |  |  | **Last Date Worked:** |  |  | **Last Date in Pay Status:** |  |

Catastrophic donations cannot be used to pay for health, dental and life insurance premiums, nor for FSA, RIC or misc. deductions.

|  |  |
| --- | --- |
|  | I understand if my base pay is not sufficient to allow premium deductions for health, dental and supplemental life insurance, I will need to set up a payment plan with my Human Resources office while I am out on leave. |

|  |  |
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|  | I understand any missed contributions to Misc. Vendors (AFLAC, Eyemed, Avesis, etc.) will need to be made directly with the vendor. |

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| Employee Signature: |  | Date: |  |

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

***Definition: “Catastrophic Illness” means a physical or mental illness or injury, as certified by a provider (MD, DO, PA, ARNP, or Psychiatrist), resulting in the inability of the employee to work for more than 30 work days on a consecutive or intermittent basis.***

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| --- | --- |
| 1. | In your opinion, does the employee’s immediate family member meet the “Catastrophic Illness” definition? Yes  No  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  If yes, hospital name: |

|  |  |  |
| --- | --- | --- |
| 5. | Prognosis: |  |

|  |  |
| --- | --- |
| **Provider’s Name(Print):** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Provider’s Signature:** |  | **Date:** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Address: |  | | |  |  |  |  |
|  | Street | | |  | City and State |  | Zip Code |
| Phone Number: | | (     ) |  |

# Part C. TO BE COMPLETED BY THE EMPLOYER

Has the employee’s diagnosis been previously filed? Yes  No  If Yes, application is denied. If no, move on to next criteria.

Please verify the following. The employee has:

an immediate family member with 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.** |

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| --- | --- | --- | --- |
| **Employer or Designee Signature:** |  | **Date**: |  |

Maintain the original in the employee’s confidential medical file.