**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.) |

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| --- | --- |
| 2.  | Diagnosis description:         |

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| --- | --- | --- |
| 3. | Method of treatment: |       |

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| --- | --- |
| 4. | Has your patient been hospital confined? Yes [ ]  No [ ]  If yes, hospital name:         |

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

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

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

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| 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.

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| **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.