CALIFORNIA STATE UNIVERSITY, STANISLAUS

HUMAN RESOURCES

CATASTROPHIC LEAVE DONATION PROGRAM

Medical Certification

Instructions: Employee to complete the employee's section below; forward to physician to complete then return to Human Resources, MSR320.

Employee's Section

Employee's Name: ______________________________ Date of Birth: ______________

I am requesting participation in the CSU's Catastrophic Leave Program for:

☐ My own catastrophic illness or injury
☐ A family member who requires my care: Name: ________________ Relationship: _______________ (refer to CBA)

I hereby authorize my physician to provide the necessary information to the employer for the purpose of verifying my disability and its expected duration to participate in the Catastrophic Leave Program.

____ _____________
Patient's signature (either employee or incapacitated family member) Date

Physician's Section

According to the Catastrophic Leave Program guidelines, a qualifying illness or injury is one that is

- catastrophic in nature;
- has totally incapacitated the employee from performing his or her normal work duties; and
- has a duration of at least one week.

An employee may also qualify if he or she is required to take time off from work for an extended period of time to care for an immediate family member who suffers from a catastrophic illness or injury. Chronic conditions such as cancer, AIDS, and residual effects of a stroke, may be considered catastrophic, even if the condition results in only intermittent absences.

Does your patient's condition fit one of these descriptions? ☐ Yes ☐ No

First date of total incapacity (or first day employee missed work to care for incapacitated family member) was/will be: ________________

Estimated date of return-to-full duty: ____________

The University is committed to providing temporary, transitional employment whenever possible. If a **reduced work schedule** or **modified work duties** would allow the employee to return to work sooner, please elaborate:

____

____

If these modifications could be met, when could the employee return to work? __________________

Physician's Name (please print or type): ________________________________ State License # __________________

Physician's Signature: ____

Address: ______________________________ City, State & Zip _____________

Phone # _______________________________

CLDP HR – 6/2009

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