

CATASTROPHIC LEAVE DONATION PROGRAM
Medical Certification

Employee's Name _____ Date of Birth: _____

This employee has requested participation in the CSU's Catastrophic Leave Program for

- the employee's own disability
- the employee's family member* who requires employee's care

* Must be an immediate family member defined as close relative or other person residing in the immediate household of the employee, except domestic employees, roomers or roommates (except for Unit 8 employees).

I hereby authorize my physician to provide the necessary information to my (or my care giver's) employer for the purpose of verifying my disability and its expected duration so that I (or my care giver) may participate in the Catastrophic Leave Program.

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



According to the CSU, Chico 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 disability (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 signature Date

 Physician's specialty State License #

Return completed form to:
 CSU, Chico
 Disability Programs Office
 Chico, CA 95929-010

 Physician's Name (please print or type)

 Address

 City, State & Zip Phone #