



**CALIFORNIA STATE UNIVERSITY CHICO**  
 HUMAN RESOURCES SERVICE CENTER  
 BENEFITS & WORKERS' COMPENSATION

400 W. 1ST STREET  
 KENDALL HALL ROOM 220  
 CHICO, CA 95929-0010  
 530-898-5436  
 FAX: 530-898-5755

**Catastrophic Leave Donation Program Medical Certification**

Employee Name \_\_\_\_\_ Employee ID#: \_\_\_\_\_

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

- own disability
- "immediate" 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.

I hereby authorize my health care provider 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 \_\_\_\_\_



TO BE COMPLETED BY HEALTH CARE PROVIDER:

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

- catastrophic in nature (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);
- has totally incapacitated the employee from performing his or her normal work duties; and
- has a duration of at least one (1) 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.

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 a temporary, transitional employment assignment 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? \_\_\_\_\_

Health Provider Name <i>(please print)</i>	Area of Specialty	State License #
Health Provider Signature	Date Signed	Phone No.
Street Address	City/State/Zip	Fax No.

Fax or mail completed form to:  
**CSU, CHICO HRSC – Benefits and Workers' Compensation Unit**  
 400 West First Street, Chico, CA 95929-0010  
 Phone: 530-898-5436 – Fax: 530-898-5755)