

***Application for Catastrophic Illness Leave Donation and Physician Verification
Due to the Need to Attend to an Immediate Family Member***

Definition - "Catastrophic Illness" means a physical or mental illness, as certified by a licensed physician, that will result in the inability of the employee to report to work for more than 30 work days on a consecutive or intermittent basis in the following twelve (12) months.

Part A. Completed by the Employee

Name of Employee Seeking Donations _____
Last First Middle Initial

Employee ID or University ID _____ Department Name _____

Home Address _____ Phone Number _____
Street Address City State Zip

Name of Family Member _____ Relationship _____

I authorize the University Benefits Office to seek additional donations when my University donations are exhausted by placing my name on the Benefits Catastrophic Leave Web Page. No medical information will be disclosed. Yes No

Information other than diagnosis will be shared with the employee's HR Unit Representative or designee to provide guidance in appropriate leave designation.

I certify that I have read and understand the definition of Catastrophic Illness and I understand that donations are to be used for absences required by the specific condition identified below. A misuse of the benefit will require reimbursement.

Signature *Date*

Part B. Completed by the Treating Physician. This information is for the purpose of determining employee eligibility for the Catastrophic Leave Program.

Does this employee require absence from work for at least 30 work days in the next 12 months due to a family member's mental or physical condition pursuant to the definition above? Yes No

If **NO**, sign and date this form and return to the employee. If **YES**, proceed to the following questions.

Diagnosis (the diagnosis is not shared with the employing department) _____

Describe in lay terms the family member's symptoms and treatment requiring the employee's absence from work _____

If the employee must be absent for a *continuous* period:

Anticipated Return to Work Date _____

If the employee must be absent from work *intermittently* for this Catastrophic Illness;

What is the frequency of these absences (ex: daily, weekly, hourly)? _____

What is the duration of each absence (ex: one day)? _____

What is the anticipated date the employee will no longer need to be absent? _____

Print Physician Name *Physician Signature (Stamps not accepted)* *Date*

Please return completed form to:
Or fax to (319) 335-2776

The University of Iowa
University Benefits Office
120 University Services Building, Suite 40
Iowa City, IA 52242-1911