DIVISION OF AGRICULTURE
RESEARCH & EXTENSION
University of Arkansas System

PMGS 20-02D
July 1, 2020

U of A System Division of Agriculture
Catastrophic Leave Bank Program Physician's Certification

Part I - (Completed by Employee)

Employee Name: _____
(Print) Last First Middle

Address: _____
Street City/State Zip

Patient Name: _____ _____
Last First Middle Relationship to Employee

Patient Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any and all information acquired in the course of my examination or treatment for the purpose of consideration by the Catastrophic Leave Committee.

_____ _____
Signature of Employee or Legal Representative Date

_____ _____
Signature of Patient or Legal Representative (If Different than Employee) Date

The employee and/or patient is responsible for the completion of this form at his/her own expense. All information listed on this form will be kept confidential.

Part II – (Completed by Employee)

When the employee and patient are the same, the employee is responsible for providing a copy of their most recent job description to the attending physician.

☐ A copy of the employee's job description is attached.

☐ The patient is not the employee therefore a job description is not attached.

Part III – (Completed by Attending Physician)

NOTE TO PHYSICIAN: This employee has applied for catastrophic leave under a plan approved by the State of Arkansas. This plan grants paid leave to an eligible employee for self or for the care of an eligible spouse or parent of the employee or of a child of the employee who experiences a ***"debilitating medical situation…severely complicated disability…and severe accident case***…"

When the employee and patient are the same, as indicated in Part II, please review the attached employee's job description and answer these questions based upon the employee's description of his/her essential job functions. **The following questions apply only to this illness/injury and all questions MUST BE ANSWERED**.

(A) First date the patient sought treatment for this illness/injury. Month_____ Day _____ 20____

(B) Frequency of visits? Weekly_____ Monthly _____ Other_____

(C) When did you last examine the patient? Month_____ Day _____ 20____

(D) First date the patient will be unable to work? Month_____ Day _____ 20____

(E) What is the minimum recovery time for the patient to return to work? _____

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Employee Name: _____
(Print) Last First Middle

(F) What is the maximum recovery time for the patient to return to work? _____

(G) May the patient return to work on a part-time basis? Yes_____ No _____

If yes, approximate date the patient will return? Month_____ Day _____ 20____

Please explain limitations:

_____
_____
_____
_____
_____

(H) Is surgery: Required? _____ Elective? _____

Date of Surgery: Month_____ Day _____ 20____

(I) Is the patient? (Check all that apply)

Ambulatory_____ House Confined _____ Bed Confined _____ Hospitalized _____

(J) Diagnosis (please give diagnosis and a brief narrative of the nature and extent of this illness/injury).

_____
_____
_____
_____
_____

(K) In your opinion what makes this illness/injury "catastrophic" from a medical standpoint:

_____
_____
_____
_____

(L) Treatment plan (please give a detailed description of the treatment plan):

_____
_____
_____
_____
_____

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Employee Name: _____
(Print) Last First Middle

Part IV– (Completed by Employee if Requesting Leave to Care for Family Member)

State the care you will provide and why is it necessary for you to provide this care for your spouse, parent, or dependent child: (Please give detailed information)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please return immediately to:
Catastrophic Leave Bank Program
c/o UADA Office of Human Resources
2301 South University Avenue
Little Rock, AR 72204
Or Fax us at: 501-671-2251

_____
Physician's Signature (no stamp) Date

_____
Print Name Clinic

_____
Address

_____
City State Zip

_____
Phone Number Fax Number

_____
Type of practice / Medical specialty