University of Arkansas, Fayetteville
State of Arkansas
Catastrophic Leave Program
Physician's Certification for Catastrophic Leave

Name: ____
(Print or Type) **Last** **First** **Middle**

Address: ____
Street **City/State** **Zip**

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.

______________________________ ______________________
(Employee's Signature or Legal Representative) **Date**

Brief Description of Employee's Job Duties: (See attached job description for full details)

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

(To be Completed by the Attending Physician)

The following questions apply only to this illness/injury:

1. **History**
   - **a.** Is the below medical information for the employee or immediate family member of the employee?
     - **i.** ☐ Employee
     - **ii.** ☐ Immediate Family Member____________________(relation)
       Why is constant care of the family member needed? ____________________________
       ____
   - **b.** When did patient first seek treatment for illness/injury?___________________(Date)
   - **c.** Could this illness/injury be work related? Yes ☐ No ☐
   - **d.** To your knowledge, has patient ever had the same or similar condition? Yes ☐ No ☐
     - **i.** If "Yes" state when and describe: ____
       ____
       ____
       ____

2. **Present Condition**
   (a) Would the employee performing any of their job duties result in a direct safety or health threat to the employee, employer, or other people (e.g. co-workers, the general public, etc.)? Yes ☐ No ☐

(b) Does the impairment or medical condition substantially limit a major life activity? Yes ☐ No ☐

(i) If yes, what major life activity is/are affected?

☐ Bending
☐ Breathing
☐ Caring for oneself
☐ Concentration
☐ Eating
☐ Hearing
☐ Bladder
☐ Bowel
☐ Brain
☐ Cardiovascular
☐ Circulatory
☐ Other:
☐ Interacting with others
☐ Learning
☐ Lifting
☐ Organic brain syndrome
☐ Digestive
☐ Endocrine
☐ Genitourinary
☐ Hemic
☐ Immune
☐ Performing manual tasks
☐ Reaching
☐ Reading
☐ Seeing
☐ Sitting
☐ Lymphatic
☐ Musculoskeletal
☐ Neurological
☐ Normal cell growth
☐ Operation of an organ
☐ Sleeping
☐ Speaking
☐ Standing
☐ Thinking
☐ Walking
☐ Working
☐ Reproductive
☐ Respiratory
☐ Special sense organs & skin

(c) Is surgery: ☐ Required? ☐ Elective? Date of Surgery___________

If surgery is elective, can the procedure be scheduled at the convenience of the employee and is it not medically necessary? ☐ Yes ☐ No

When was the patient informed of surgery by the attending physician? ____________(Date)

(d) Is patient? (Check One) ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized

3. Diagnosis: Give a complete narrative of the nature and extent of the present illness/injury which is creating the need for the Catastrophic Leave Program. For example: stating the employee/ patient has skin cancer is not sufficient; further stating the cancer is basal cell or melanoma is needed, or stating the employee/patient requires or has had abdominal surgery is not sufficient; further stating whether the surgery is/was laparoscopic or open surgery is needed.

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4. Treatment for this illness/injury

(a) Date of first visit/treatment: ____________

(b) Frequency of visits/treatments: ☐ weekly ☐ monthly ______________________other

(c) When did you last examine the patient?_________________(Date)

(d) Give a brief description of the continuing treatments required by this illness/injury:

____
____
____

5. Prognosis

(a) If there are no further complications, what is the minimum recovery time to return to work? Approximate return date: ____

(b) What is the maximum recovery time to return to work? Approximate return date:_____________________

(c) Would there be the possibility of this patient returning to work on a part-time basis with job duties altered within reason to better fit his/her needs? ☐ Yes ☐ No If yes, Approximate return date:____________

Explain limitations: ____

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Please feel free to attach any additional documentation

Clinic Name	Signature of Attending Physician	Telephone
Address	Date	Fax Number