



**EMPLOYEE/PHYSICIAN
CATASTROPHIC LEAVE APPLICATION FORM**

Name: _____

Date: _____

Dept: _____

Contact number: _____

Current employment status:

- Working ____ hours per week
- Sick leave with compensation
- Leave without pay

Section to be completed by requesting employee:

Please state the reason for your request to use donated time. Include any information related to your catastrophic condition that may assist the review board.

Please provide the names and contact information for each physician treating your illness:

Name:

Address:

Phone:

Section to be completed by the requesting employee's physician:

The patient is:

- Permanently unable to complete a substantial portion of his/her job duties.
- Temporarily unable to complete a substantial portion of his/her job duties.

1. What is the employee's prognosis?

2. In your opinion will the employee be able to return to work? If so, please estimate a time frame.

3. Will work restrictions apply?

Physicians' signature _____

Date: _____

(A stamped signature will not be accepted)