UNT SYSTEM
Human Resources

Family Leave Pool Health Care Provider Medical Certification

I authorize my licensed health care provider_____ to release the information requested on this form, and/or any additional relevant information concerning my health condition, to the Pool Administrator.

Patient's Printed Name: _____

Patient's Signature: _____ Date:_____

Employee's Printed Name (if different than Patient's Name):_____

To be completed by provider:

Answer, fully and completely, all applicable sections. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "unknown or indeterminate" may not be sufficient to determine if pool donation criteria is met. ***Please be sure to sign this form.***
The employee identified above has applied for the University's family leave pool donation benefits. The information requested will be used solely to determine the employee's eligibility for this benefit.
1. Diagnosis:
2. Is the condition arising from Occupational injuries or illness related to current employment? If so, the employee is not eligible for an award of Pool Donation. The employee should contact their manager to report a work-related condition. _____yes _____no
3. **Serious Medical Condition:** a major illness or other medical condition (e.g., heart attack, cancer, etc.) that required a prolonged absence from work, including intermittent absences that are related to the same illness or condition. Does this employee meet the definition of Serious Medical Condition? _____yes _____no
Licensed Provider Signature:
Print Name: Date:
Office telephone #: Office Fax #:
Office Address: