UNT SYSTEM
Human Resources

Sick Leave Direct Donation 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. The information requested will be used solely to determine the employee's eligibility for a sick leave direct donation benefit. ***Please be sure to sign this form.***
Please indicate dates or date range of absences anticipated due to this condition. Continuous: From: To: Intermittent: From: To: Frequency: times per week(s) month Duration: hours or days per episode
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 Donation. The employee should contact their manager to report a work-related condition. _____yes _____no
Medical Emergency. "Medical emergency means" a medical condition of the employee that will require the prolonged/extended absence of the employee from duty and will result in a substantial loss of income to the employee due to the exhaustion of all paid leave. Does this condition meet the definition of Medical Emergency? ☐ Yes ☐ No
Licensed Provider Signature:
Print Name: Date:
Office telephone #: Office Fax #:
Office Address: