UNT SYSTEM Human Resources

Sick Leave Pool / Sick Leave Donation
Practitioner Certification

Employee's Printed Name _____ Employee ID _____ Patient's Name (if different from employee) _____

I authorize my licensed practitioner _____ to release the information requested on this form, and/or any additional relevant information concerning my health condition, to the Sick Leave Donation / Pool Administrator.

Patient's Signature: _____

For Completion by a Licensed Practitioner:

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 Sick Donation criteria is met. ***Please be sure to sign this form.***

Definitions: Sick Leave Pool (Catastrophic Illness or Injury) or Sick Leave Donation (Serious Health Condition)

1. A **catastrophic illness or injury**, is a severe condition or combination of conditions affecting the mental or physical health of the employee or the employee's immediate family that requires the services of a licensed practitioner for a prolonged period of time.

   A "severe condition or combination of conditions" is one that:
   - Will result in death or is a severely debilitating condition that will result in the individual not meeting the essential functions of their job if not treated promptly or at regularly scheduled intervals (e.g. chemotherapy treatments, radiation treatments, etc.); or
   - Has been designated as terminal; or
   - Will require an absence from work for at least 45 continuous calendar days.

Conditions eligible for Sick Leave Pool must be considered a catastrophic illness. For purposes of Sick Leave Pool, pregnancy and elective surgery are not considered catastrophic conditions, except when life-threatening complications arise from them.

2. A **serious health condition**, as defined by the U.S. DOL Wage and Hours Division, means an illness, injury, impairment, or physical or mental condition that involves:

- any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility; or
- a period of incapacity requiring absence of more than three calendar days from work, school, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a health care provider; or
- any period of incapacity due to pregnancy, or for prenatal care; or
- any period of incapacity (or treatment therefore) due to a chronic serious health condition (e.g., asthma, diabetes, epilepsy, etc.); or
- a period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's, stroke, terminal diseases, etc.); or,
- any absences to receive multiple treatments (including any period of recovery therefrom) by, or on referral by, a health care provider for a condition that likely would result in incapacity of more than three consecutive days if left untreated (e.g., chemotherapy, physical therapy, dialysis, etc.).

3. The **Genetic Information Nondiscrimination Act of 2008 (GINA)** prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Part A: Medical Facts

Medical facts, symptoms, and / or diagnosis of condition:

Is the condition arising from occupational injuries or illnesses related to current employment? ☐ Yes ☐ No

If Yes, STOP HERE. Occupational injuries or illnesses related to current employment are not eligible for an award of Sick Leave Pool or Sick Leave Donation. The employee may still qualify for benefits under the workers' compensation program. The employee should contact their manager to report a work-related condition.

Check the box below to confirm, if this leave is for a Catastrophic Illness/Injury or a Serious Health Condition:
☐ **Catastrophic Illness/Injury** (complete ***Section I*** for **Sick Leave Pool**) or
☐ **Serious Health Condition** (complete ***Section II*** for **Sick Leave Donation**)

Section I (Sick Leave Pool):

1. Is this treatment considered elective? ☐ Yes ☐ No
2. Has this condition been designated as terminal? ☐ Yes ☐ No
3. Will this severe condition or combination of severe conditions result in death or is a severely debilitating condition that will result in the individual not meeting the essential functions of their job if not treated promptly or at regularly scheduled intervals (e.g. chemotherapy treatments, radiation treatments, etc.)? ☐ Yes ☐ No

   If yes, please explain: _____

   _____

   _____
4. Has this severe condition or combination of severe conditions required hospitalization for more than 72 consecutive hours? ☐ Yes ☐ No
5. Is the patient's condition a catastrophic illness or injury, which is defined as a severe condition or combination of conditions affecting the mental or physical health of the employee that requires the services of a licensed practitioner for a prolonged period of time? ☐ Yes ☐ No
6. Will this condition require an absence from work for at least 45 continuous calendar days? ☐ Yes ☐ No

If you answered YES to one or all of Questions #4 thru #6 please provide the following:

☐ Continuous Leave
From: _____ **To**: _____

☐ Intermittent Leave
From: _____ **To**: _____
Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hours or _____ day(s) per episode

Section II (Sick Leave Donation):

1. Does the patient's diagnosis meet the Department of Labor's Wage and Hours Division definition of Serious Health Condition, requiring a prolonged absence from work, including intermittent absences that are related to the same illness or condition? ☐ Yes ☐ No
2. Will this condition require an absence from work for at least four continuous calendar days? ☐ Yes ☐ No

   If Yes, please provide the dates: From:_____ To: _____

   Please Note: *For pregnancy, you will need only to provide the period of incapacitation and or period for prenatal care, and **not** baby bonding.*
3. Will this condition require an intermittent absence from work? ☐ Yes ☐ No

   If Yes, please provide the dates and, describe the intermittent absence to include frequency and duration:

   From: _____ **To**: _____

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or _____ day(s) per episode

_____ _____
Licensed Practitioner Signature Date

_____
Practitioner Printed Name

Office telephone: ( ) - Office Fax: ( ) -

Office Address: _____

_____

Submit completed forms to
UNT System Human Resources Benefits
Department Fax: (940) 369-5530
Email: FMLA@untsystem.edu *Need Help?*
Call (940) 369-7650 option 5