UNT SYSTEM
Human Resources

Sick Leave Pool Health Care Provider
Medical Certification

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

I authorize my 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 Signature: _____

For Completion by Health Care 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 Sick Pool 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:

a. 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
b. Has been designated as terminal; or
c. 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.

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.

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

Health Care Provider Signature _____

Printed Name _____

Office Number: _____

Submit completed forms to

UNT System Human Resources BenefitsDepartment Fax: (940) 369-5697

Email: *FMLA@untsystem.edu* *Need Help?*

Call (940) 369-7650 option 5