University Human Resources
Benefits Office

Application for Catastrophic Illness Leave Donation and Healthcare Provider Certification

"Catastrophic Illness" means a physical or mental illness, as certified by a licensed physician, which will result in the inability of the employee to report to work for more than 30 work days (6 weeks) on a consecutive or intermittent basis during a 12 month period.

Applications received after return to work date will not be considered. Do not apply if you have returned to work.

Part A. Completed by the Employee. Please provide all requested information. Incomplete applications will be returned to employee.

Name of Employee Seeking Donations _____
Last First Middle Initial

University ID _____ Last Date Worked _____

Home Address _____ Phone Number _____
Street Address City State Zip

Department Name _____ Department Contact _____

Information will be shared with the employee's HR Representative or designee to provide guidance in appropriate leave designation.

I authorize the University Benefits Office to seek additional donations when my accrued leave balances are exhausted by placing my name on the Benefits Catastrophic Leave Web Page. No medical information will be disclosed. ☐ Yes ☐ No

I am currently receiving workers' compensation benefits. ☐ Yes ☐ No

An employee must have exhausted all paid leave and not be receiving long-term disability in order to qualify for donations. Total donations received shall not exceed the amount necessary to cover the long-term disability waiting period. I certify that I have read and understand the definition of Catastrophic Illness and I understand that donations are to be used for absences required by the specific condition identified below. A misuse of the benefit will require reimbursement.

_____ _____
Signature of Employee *Date*

Part B. Completed by the Treating Physician. This information is for the purpose of determining employee eligibility for the Catastrophic Leave Program. Please provide all requested information. Incomplete applications will be returned.

Does this employee require absence from work for at least 30 work days on a consecutive or intermittent basis in the next 12 months due to a mental or physical condition pursuant to the definition above? ☐ Yes ☐ No

If **NO**, sign and date this form and return to the employee. If **YES**, proceed to the following questions.

Diagnosis Description and Method of Treatment: _____

_____

Will employee be absent for a consecutive period or an intermittent period? ☐ Consecutive ☐ Intermittent

If the employee must be absent from work *intermittently*, what is the frequency and duration of these absences? _____

_____

Date employee was first unable to work: _____ Anticipated return to work date: _____

_____ _____ _____
Print Physician Name *Physician Signature (Stamps not accepted)* *Date*

Note to Health Care provider: To comply with The Genetic Information Nondiscrimination Act of 2008 (GINA), please do not provide any genetic information when responding to this request for medical information. "Genetic Information" 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.

Please return completed form to:
University Benefits Office
120 University Services Building
Iowa City, IA 52242-1911
Fax: 319-335-2776
E-mail: benefits@uiowa.edu