IOWA University Human Resources Benefits Office

CATASTROPHIC LEAVE APPLICATION & MEDICAL CERTIFICATION FOR FAMILY MEMBER

"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 workdays (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 submit all required information. Incomplete applications will be returned.

Name of Employee Seeking Donations (Last, First, Middle Initial)**:**

University ID Number: **Last Day Worked:**

Home Address
(Street, City, State, Zip): **Phone Number:**

Name of Family Member: **Date of Birth:** **Relationship:**

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

Immediate family member means the employee's spouse, parent, or child as defined by the Family and Medical Leave Act of 1993. An employee must have exhausted all paid leave. Total donations received shall not be used beyond one year (12-months) for the family member's specified medical condition. 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 conditions identified below. I further understand that participation in the program ends in the event of the family member's death. 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 Catastrophic Leave. Incomplete applications will be returned.

Does this employee require absence from work for at least 30 workdays on a consecutive or intermittent basis in the next 12 months due to a family member's 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 with the following questions:

Diagnosis Description and Method of Treatment:

Will the employee be absent for a consecutive period or 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 the completed form to:
University Benefits Office, 120 University Services Building, Iowa City, IA 52242 | Fax: 319-335-2776 | E-mail: benefits@uiowa.edu