

## Request for Sick Leave Pool For Catastrophic/Life Threatening Condition Health Care Provider Certification

Employee's Name \_\_\_\_\_

Patient's Name (if different from employee) \_\_\_\_\_

### For Completion by HEALTH CARE PROVIDER

Answer, fully and completely, all applicable parts. Your answer 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 Leave Pool criteria is met. **Please be sure to sign the form on the last page.**

### Part A: MEDICAL FACTS

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

1. Does the patient's condition qualify under the following?  Yes  No **If Yes, check all that apply:**

- Result in death if not treated promptly
- Result in the loss of an arm, leg, major appendage if not treated promptly
- Result in the permanent inability to self ambulate if not treated promptly
- Result in the loss or significant limitation of the sense of touch, hearing or sight
- Mental or behavioral health condition causes patient to be incapable of self-care
- Declared a danger to him or herself or others

**If No, STOP HERE.** The condition(s) does not qualify for an award of Sick Leave Pool. The employee may still qualify for unpaid FMLA or other leave options. The employee should contact Human Resource Services to discuss all other available leave options.

2. Is the condition arising out of the employee's 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. The employee may still qualify for benefits under the workers' compensation program. The employee should contact their manager to report a work-related condition.

3. Catastrophic Condition(s)

a. Primary Diagnosis and Diagnosis Code: \_\_\_\_\_

b. Secondary Diagnosis and Diagnosis Code: \_\_\_\_\_

c. Other Diagnoses: \_\_\_\_\_

4. Approximate date condition(s) commenced and date(s) you treated the patient:

Was the patient recently admitted for an overnight stay in a hospital, hospice, or residential medical facility?  Yes  No

If yes, dates of admission: \_\_\_\_\_

5. Is life saving surgery needed?  Yes  No If Yes, provide surgery date \_\_\_\_\_ and type of procedure(s):

6. If the request for Sick Leave Pool is due to behavioral or mental health condition, please provide the most recent Global Assessment of Functioning Score (GAF). GAF Score: \_\_\_\_\_ Date of last GAF: \_\_\_\_\_
7. Describe other relevant medical facts, if any, related to the condition for which the employee seeks an award of Sick Leave Pool (such facts may include symptoms, medication or any regimen of continuing treatment, e.g., radiation or chemotherapy appointments):

Findings that substantiate the catastrophic nature of the condition such as lab results, admission or discharge summaries may be needed. Human Resource Services will contact the employee if these are requested.

**Part B: AMOUNT OF LEAVE NEEDED**

8. Will the employee/family member be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  Yes  No

If Yes, estimate the beginning and ending dates for the period of incapacity \_\_\_\_\_  
Beginning date Ending date

9. Will the employee need to work part-time or on a reduced schedule because of the medical condition?  Yes  No

Estimate the part-time or reduced work schedule the employee needs to care for their own or family member's condition, if any:

\_\_\_\_\_ Hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_  
Beginning date ending date

10. If the employee's leave is required to care for an immediate family member with a catastrophic condition, what are the patient's needs involving the employee? (Check all that apply)

- Medical assistance  Transportation  
 Psychological support  Assistance with activities of daily living

11. Will the condition cause episodic flare-ups periodically preventing the employee from coming to work?  Yes  No  
Estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**Part C: LICENSED HEALTH CARE PROVIDER INFORMATION**

Provider's name: \_\_\_\_\_

Business address: \_\_\_\_\_

Type of practice/Medical specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

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