UTRGV **Human Resources**
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THE UNIVERSITY OF TEXAS RIO GRANDE VALLEY

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

Notice Concerning Your Information: The Texas Public Information Act, with a few exceptions, gives you the right to be informed about the information that The University of Texas Rio Grande Valley collects about you. It also gives you the right to request a copy of that information; and to have the University correct any of that information that is wrong.