Imperial Valley College

CATASTROPHIC LEAVE DONATION PROGRAM

Verification of Eligibility

THIS FORM IS USED TO REQUEST PARTICIPATION IN THE CATASTROPHIC LEAVE DONATION PROGRAM

INSTRUCTIONS: Please read guidelines carefully. Fill out employee portion of this form, sign, date request, and submit to treating physician to complete Physician Certification. Return completed form to Travis Gregory Administrative Dean of Human Resources, 2400 Building; faxes also accepted to (760) 355-6211. Questions regarding this program should be directed to Human Resources (760) 355- 6212.

CATASTROPHIC LEAVE DONATION GUIDELINES

The Catastrophic Leave Donation Program is intended to provide a recipient employee with donated leave credits. To qualify for the Catastrophic Leave Donation Program, the recipient employee must have a catastrophic illness or injury that has totally incapacitated the employee from work, or have an immediate family member who is totally incapacitated due to illness or injury and requires the employee to care for the family member. The recipient employee must be on an approved leave of absence, and request participation in the Catastrophic Leave Donation Program by completing this form. *All applicable contract provisions apply*.

Chronic conditions associated with the debilitating illness or injury that results in intermittent absences from work may be considered catastrophic, i.e., cancer, AIDS, residual effects of a stroke, etc. Short–term conditions such as colds, flu, and /or common illnesses or injuries are not deemed catastrophic.

EMPLOYEE REQUEST FOR PARTICIPATION

I have read the guidelines and elected participation in the Catastrophic Leave Donation Program. I hereby authorize the treating physician to release the required information requested below to Imperial Valley College for purposes of determining eligibility for participation.

Catastrophic Leave Donation Program Request for:	☐ Self ☐ Immediate family member
A description of the catastrophic illness or injury:	

_____ _____

Employee Name (Please Print) Employee Signature (or Agent)

_____ _____

Patient's Name (if Family Member) Relationship to Employee

PHYSICIAN CERTIFICATION

NOTE: HEALTH CARE PROVIDER IS <u>NOT</u> TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT CONSENT OF PATIENT.

As treating physician for the above named employee (or employee's immediate family member), I hereby certify that the employee (or employee's immediate family member) has a catastrophic illness or injury that is totally incapacitating as defines in the above guidelines:

Duration of Leave: From: _____ **To:** _____

Physician Name
(Please Print): _____ Telephone: _____

Type of Practice: _____

Signature of Treating Physician: _____ Date: _____