

Physician's Certification for Catastrophic Leave Request - Immediate Family Member

The State of Nevada's Catastrophic Leave program allows State employees to donate excess sick or annual leave to eligible co-workers who have experienced a catastrophe and have exhausted their own paid leave balances. As per NAC 284.576, an appointing authority may require the following form to be completed in order to substantiate the need for leave.

Section I (to be completed by the employee):

Employee name: _____ Employee ID#: _____

Patient name and relationship: _____

Employee signature: _____ Date: _____

Section II (to be completed by the attending health care provider):

1. Describe the serious illness, accident or motor vehicle crash which supports the need for leave. If your patient experienced an accident or motor vehicle crash, describe the medical conditions that resulted from that accident or motor vehicle crash.

- a. If yes, what is the date the serious illness commenced or the accident or motor vehicle crash occurred?

2. Is your patient's serious illness or medical condition "life threatening" resulting in a substantial risk of death? No Yes

- a. If yes, please explain. _____

3. Does your patient have a serious illness or medical condition requiring a convalescence which you expect to exceed 10 *consecutive* weeks? No Yes

- a. If yes, please explain. _____

4. Estimate the beginning and ending dates for the period of needed care due to the patient's incapacity:

5. Explain the care needed by the patient and why such care is medically necessary:

6. Will your patient need follow-up treatment following the period of incapacity (see question 4)? No Yes

- a. If yes, what is the nature of the follow-up treatment? _____

- b. If yes, how frequently will the follow-up treatment be required? _____

- c. If yes, when do you expect your patient to complete his/her follow-up treatment (date or length of time):

Health care provider name: _____

Type of practice – field of specialty: _____

Address: _____

Telephone number: _____

Signature of health care provider: _____

Date: _____