CAL MARITIME

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 form, sign, date request, and submit to treating physician to complete Physician Certification. Return completed form to Barbara Reece, HR and Benefits Coordinator, 200 Maritime Academy Drive, Vallejo, CA 94590-8181. Questions regarding this program should be directed to Barbara Reece at 707.654.1021.

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 in order to request and receive donations.

EMPLOYEE REQUEST FOR PARTICIPATION: I have read the guidelines and elect participation in the Catastrophic Leave Donation Program. I hereby authorize the treating physician to release the required information request below to California State University, California Maritime Academy for purposes of determining my eligibility for participation.

Catastrophic Leave Donation Program Request for: ☐ Self ☐ Immediate Family Member

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

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

PHYSICIAN CERTIFICATION: ***HEALTHCARE PROVIDER IS NOT TO DISCLOSE UNDERLYING DIAGNOSIS WITHOUT PATIENT'S CONSENT***
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 defined in the above guidelines:

Duration of Leave: From: _____ To: _____

Physician Name: (Please Print) _____ Telephone: _____

Type of Practice: _____

Street Address: _____

City, State, Zip: _____

Signature of Treating Physician: _____ Date: _____

HR ADMINISTRATIVE USE ONLY ☐ **APPROVED** ☐ **DENIED**

SIGNATURE: **DATE:**