



Donated Leave Program

PHYSICIANS' CERTIFICATION FORM

Part A. To Be Completed by the Employee

Employee Name/Print Panther # FTE Phone #

Department & P.O. Box Street Address City State Zip Code

Part B. To Be Completed by the Physician

Definition: Life-threatening or emergency medical condition means a health condition involving a serious, extreme, or life-threatening illness, injury, impairment, or condition that is likely to require the employee's absence from work for an extended period of time longer than the amount of sick and annual leave available to the employee, and the health condition is such that it is not medically appropriate for the employee to delay the absence in order to accrue additional sick or annual leave prior to the absence. Some examples of such conditions include: advanced or rapidly growing cancers, acute life-threatening illnesses, chronic life-threatening conditions involving failure of bodily organs or systems (e.g., heart attack). The absence may be continuous, as in hospitalization following surgery or an accident, or intermittent, as in periodic absences for chemotherapy or other procedures.

1. In your opinion does the employee meet the "Life-threatening or emergency medical condition" definition as described above? Yes No (Check One) (Attach additional sheet if more space is needed).

2. Date patient was first unable to work

3. Diagnosis description:

4. Method of treatment:

5. Has the patient been hospital confined? Yes No (Check One) If yes, provide hospital name and admittance date:

6. Prognosis: (probable duration of condition)

7. When could patient resume work? (List any restrictions to regular duty)

Physician's Name: (Please Print) Specialization

Address:

Physician's Signature: Date: (Please do not use Stamp or Designee Signature)

**Part C. To Be Completed by the Employee or Person acting on behalf of the Employee**

I understand that the information requested on this Physician's Certification of Emergency or Life Threatening Medical Condition Form is for the use of determining my eligibility to participate in the Donated Leave Program at Georgia State University. Failure to provide all the requested information will result in my request not being processed or approved by the Donated Leave Certification Committee. Further, I am aware that any medical information provided will remain confidential and will not be shared with other employees in Human Resources, my Department or elsewhere within the University. If I am acting on behalf of the employee patient, I am providing documentation as having Power of Attorney with this form.

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Employee Patient Signature

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Date

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Print Name of Person acting on behalf of the Employee Patient

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Date

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Signature of person acting on behalf of the Employee Patient

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Date