Print Form

University of Northern Iowa

Human Resource Services

Catastrophic Leave Request

Section I: Employee Certification

Name: _____ **Preferred Email:** _____

Home Phone: _____ **University ID:** _____ **Last Date Worked:** _____

Department Supervisor & Phone Number: _____

Are you currently receiving workers' compensation benefits? ☐ Yes ☐ No

I certify that I have read and understand UNI Policy 4.48, including the definition of personal catastrophic illness or injury reflected below. I understand that I must exhaust all of my paid leave and not be receiving long term disability benefits in order to accept donations. I understand any donations are to be used for absences required by the specific condition certified by my healthcare provider below. I also understand that I cannot receive or use more than the amount of catastrophic leave donations necessary to cover the waiting period for long term disability benefits.

Signature: _____ **Date:** _____

Section II: Healthcare Provider Certification

A personal catastrophic illness or injury is defined as a medical condition for which a healthcare provider has certified is likely to result in a loss of 30 or more work days in a six month period.

In your opinion, does the employee meet the above definition of personal catastrophic illness or injury?

☐ No ▸ If **NO**, sign and date this form and return to Human Resource Services.

☐ Yes ▸ If **YES**, complete the form and return to Human Resource Services.

Diagnosis Description and Method of Treatment:

_____

_____

Will employee be absent for a continuous or intermittent period? ☐ Continuous ☐ Intermittent

Date employee was first unable to work: _____ Anticipated return to work date: _____

Healthcare Provider's Printed Name: _____

Healthcare Provider's Signature: _____ **Date:** _____

Note: Please return completed form to Human Resource Services **Fax: 319.273.2430**

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