Request for Sick Leave Pool / Donation
Health Care Provider Certification

Employee Name _____ Contact Phone Number _____

Department _____ Campus ID # _____

My signature authorizes the health care provider to submit paperwork directly to Midwestern State Human Resources.

_____ _____

Employee Signature Date

For Completion by HEALTH CARE PROVIDER

Answer, fully and completely, all applicable parts. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient to determine if Sick Leave Pool / Donation criteria is met. **Be sure to sign the form on the last page.**

Part A: MEDICAL FACTS

Conditions eligible for Sick Leave Pool or Donation awards must be considered catastrophic. For these purposes, pregnancy and elective surgery are not considered catastrophic conditions, except when life-threatening complications arise from them.

Patient's Name _____

1. Is the condition arising out of the employee's current employment? ☐ Yes ☐ No

Occupational injuries or illnesses related to current employment are not eligible for an award of Sick Leave Pool or Donation. The employee may still qualify for benefits under the worker's compensation program and/or Family Medical Leave (FML). The employee should contact their manager to report a work-related condition.

2. Does the patient's condition qualify under the following? ☐ Yes ☐ No **If Yes**, check all that apply:

- ☐ Result in death if not treated properly
- ☐ Declared a danger to him or herself and requiring intensive treatment, including at a hospital or facility
- ☐ Declared a danger to others
- ☐ Mental or behavioral health condition causes patient to be incapable of self-care and requiring intensive treatment
- ☐ Result in the permanent inability to self ambulate if not treated promptly
- ☐ Result in the loss or significant limitation of the sense of touch, hearing, or sight
- ☐ Result in the loss of an arm, leg, major appendage if not treated promptly

For any checked box, please explain: _____

If No, the condition(s) does not qualify for an award of Sick Leave Pool or Donation. The employee may still qualify for FMLA.

3. Condition(s)

a. Primary Diagnosis: _____

b. Secondary Diagnosis: _____

c. Other Diagnoses: _____

4. Approximate date condition(s) commenced and date(s) you treated the patient:

_____

Was the patient recently admitted for an overnight stay in a hospital, hospice,or residential medical facility? ☐ Yes ☐ No

If yes, dates of admission _____

5. Is life saving surgery needed? ☐ Yes ☐ No

If yes, provide surgery date: _____ and type of procedure(s):

6. Describe other relevant medical facts, if any, related to the condition for which the employee seeks an award of Sick Leave Pool or Donation (*such facts may include symptoms, medication, or any regimen of continuing treatment, e.g., radiation or chemotherapy appointment*):

Findings that substantiate the catastrophic nature of the condition such as lab results, admission, or discharge summaries may be needed. Human Resource Services will contact the employee if these are requested.

Part B: AMOUNT OF LEAVE NEEDED

7. Will the employee/family member be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery. ☐ Yes ☐ No

If Yes, estimate the beginning and ending dates for the period of incapacity: _____ (Beginning date) _____ (Ending date)

8. Will the employee need to work part-time or on a reduced schedule because of the medical condition? ☐ Yes ☐ No

Estimate the part-time or reduced work schedule the employee needs to care for their own or family member's condition, if any:

_____ Hour(s) per day _____ Days per week from _____ (Beginning date) through _____ (Ending date)

9. If the employee's leave is required to care for an immediate family member with a catastrophic condition, what are the patient's needs involving the employee? (check all that apply)

☐ Medical assistance ☐ Transportation ☐ Psychological Support ☐ Assistance with activities of daily living

10. Will the condition cause episodic flare-ups periodically preventing the employee from coming to work? ☐ Yes ☐ No

Estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ hours or day(s) per episode

Part C: PHYSICIAN'S INFORMATION

Name _____ Phone Number _____

Address _____ Fax Number _____

_____ _____

Physician Signature Date:

Please return the form to the employee or, if authorized by the employee, submit directly :
Mail: Midwestern State University
3410 Taft Blvd.
Wichita Falls, Texas 76308
Fax: (940) 397-4780
E-mail: Human.resources@msutexas.edu

Notice Concerning Your Information: The Texas Public Information Act, with a few exceptions, gives you the right to be informed about the information that Midwestern State collects about you. It also gives you the right to request a copy of that information; and to have the University correct any of that information that is wrong. You may request to receive and review any of that information or request corrections to it, by contacting the Human Resources Department, 3410 Taft Blvd. (e-mail: human.resources@msutexas.edu).