UAMS CATASTROPHIC LEAVE BANK PROGRAM
PHYSICIAN STATEMENT FORM

Please print or type

Part I – (Completed by Employee)

Employee Name: ____
Last First Middle

Address : ____
Street City/State Zip

Patient Name: ____
Last First Middle

Relationship to Employee: ______________________ Date of Birth: ____________________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any and all information acquired in the course of my examination or treatment for the purpose of consideration by the Catastrophic Leave Committee.

______________________________ ______________
Employee Signature (or Legal Representative) Date

______________________________ ______________
Patient's Signature or Legal Representative (If Different than Employee) Date

THE EMPLOYEE AND/OR PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM AT HIS/HER OWN EXPENSE. ALL INFORMATION LISTED ON THIS FORM WILL BE KEPT CONFIENTIAL.

PART II – (Completed by Attending Physician)

NOTE TO PHYSICIAN: This employee has applied for catastrophic leave under a plan approved by the State of Arkansas. This plan grants paid leave to an eligible employee or spouse or parent of the employee or of a child of the employee who experiences a ***"debilitating medical situation…severely complicated disability…and severe accident case****…*". Please help us evaluate this leave request. **The following questions apply only to this illness/injury and all questions MUST BE ANSWERED**.

(A) First date the patient sought treatment for this illness/injury. Month______ Day ______ 20____

(B) First date the patient will be unable to work? Month______ Day ______ 20____

(C) Anticipated date the patient will return to work? Month______ Day ______ 20____

(D) Is surgery: Required? ______ Elective? ______ Date of Surgery : Month______ Day ______ 20____

(E) Diagnosis (please give diagnosis and a brief narrative of the nature and extent of this illness/injury). In your opinion what makes this illness/injury "catastrophic" from a medical standpoint:

____

____

(F) Treatment plan (please give a brief description of the treatment plan):

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____

Additional Documentation may be attached.

____
Physician's Signature Date

____
Print Name Clinic

____
Address

____
City State Zip

____
Phone Number Fax Number

Please Return to:
Catastrophic Leave Bank Program
c/o UAMS Office of Human Resources
4301 West Markham, Slot 566
Little Rock, Arkansas 72205
Or Fax us at: 501-686-5386