Department of Transformation and Shared Services
Office of Personnel Management

Catastrophic Leave Program Physician's Certification

Note: *The employee and/or patient is responsible for the completion of this form at his or her own expense. All information listed on this form will be kept confidential and is not to be released to or by the employer without written consent of the employee.*

Name of Employee (Last, First)

Address (Street, City, State, Zip)

Name of Patient (Last, First)

Authorization to Release Information: I hereby authorize the undersigned physician to release information acquired in the course of my examination or treatment to my employer.My employer will provide his certification to the OPM Catastrophic Leave Bank Program for eligibility determination purposed for short-term disability benefits. I understand that this authorization to disclose information will expire thirty (30) days after the date of my signature or upon receipt by the physician of my written revocation, whichever comes first.

Employee's Signature
(or Legal Representative)

Date

Patient's Signature or Legal Representative
(if Different than Employee)

Date

To Be Completed by Patient's Physician

The following questions apply only to the conditions related to the patient's application for short-term disability benefits from the State of Arkansas Catastrophic Leave Bank Program - Medical Emergency due to Illness/Injury.

1. History

(a) When did patient first seek treatment for this illness/injury?

Date

(b) Could this illness/injury be work related? ☐ Yes ☐ No

(c) To your knowledge, has patient ever had the same or similar condition? ☐ Yes ☐ No
If "Yes," state when and describe:

2. Present Condition

(a) Is surgery: ☐ Required? ☐ Elective? Date of Surgery:

When was the patient informed by the attending physician?

Date

(b) Is patient *(check one)* ? ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized

3. Diagnosis **Give a *COMPLETE* narrative of the nature and extent of the present illness/injury which is creating the need for short-term disability provided by the State's Catastrophic Leave Bank Program. Please be specific.** For example: Stating the employee/patient has skin cancer is not sufficient; further stating the cancer is basal cell or melanoma is needed, or, stating the employee/patient requires or has had abdominal surgery is not sufficient; further stating whether the surgery is/was laparoscopic or open surgery is needed.

4. Continuing Required Treatment for this Illness/Injury

(a) Projected Date of first office visit/treatment:

(b) Frequency of visits/treatments ☐ Weekly ☐ Monthly ☐ Other _____

(c) When did you last examine patient?

(d) Give a brief description of the continuing treatments required by this illness/injury:

5. Prognosis and Anticipated Time Duration that Employee Will Be Unable To Work Due To The Health Condition of Employee or Required Direct Care of a Family Member

(a) If there are no further complications, what is the minimum recovery time of the patient before the employee may return to work?

Approximate Return Date:

(b) What is the maximum recovery time of the patient before the employee may return to work?

Approximate Return Date:

(c) If the patient is a State Employee, is there a possibility of working intermittent or reduced schedule or returning to work on a part-time basis with job duties altered, within reason, to better fit his/her needs?

☐ Yes ☐ No If yes, Approximate Return Date:

Please explain any limitations:

Clinic Name	Address	Telephone
Physician's Name (print)	Physician's Signature	Date