UNIVERSITY OF HAWAI'I CERTIFICATION OF PHYSICIAN FOR PERSONAL ILLNESS/INJURY

SECTION 1: EMPLOYEE INFORMATION (Employee to Complete)

I hereby authorize my physician to provide the medical information as requested below in support of my leave sharing request. Also, if requested, I authorize my physician to release his/her clinical notes regarding my medical diagnosis, treatment, prognosis, etc., to be used in determining my eligibility for the Leave Sharing Program.

Employee's Signature

Date

SECTION II: MEDICAL CERTIFICATION (Physician to Complete)

The above employee is applying for shared leave (leave donations from co-workers and/or the Central Leave Bank) due to his/her serious illness/injury. Please answer the form as fully and completely as possible and be specific; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine shared leave eligibility.

In order to be eligible for the Leave Sharing Program, the employee must meet the following criteria: The illness or injury must be life threatening or critical, severe, debilitating and catastrophic in nature, such as cancer, heart attack or a disabling accident which does not include minor surgeries, routine pregnancies, illnesses due to colds or flus, broken limbs, or other non-critical conditions; and must be totally incapacitating to cause the inability to work for at least thirty (30) consecutive days.

Describe in detail medical facts/symptoms/diagnosis/treatment (attach additional sheet if needed):

THE ABOVE PATIENT'S CONDITION IS:

(COMPLETE A, B, & C – provide an explanation and do not leave any questions blank)

A.	Life Threatening	🗆 No	□ Yes		
	I certify my clinical notes support this claim:	□ No	□ Yes		
If "Yes", approximate date condition commenced:					
	e duration of condition: From				
Explain the condition:					
-					

B.	Critical, severe, debilitating and catastrophic in nature I certify my clinical notes support this claim:			l No l No	□ Yes □ Yes	
If "Ye	es", approximate date condition commenced:					
Proba	Probable duration of condition: From to to					
Expla	in the medical findings supporting how the patient's he	alth conditi	ion meets th	e definition	above	
(critic	cal, severe, debilitating and catastrophic in nature):					
~						
C.	Totally incapacitatingII certify my clinical notes support this claim:I		□ Yes □ Yes			
If "Ye	es", approximate date condition commenced:					
Proba	ble duration of condition: From		to			
	in the medical findings supporting how the patient's he					
incapa	acitating to cause the inability to work:					
	ify that the above-named individual is suffering from an					
	al, severe, debilitating and catastrophic in nature, which working. I further certify my clinical notes support all o		e employee t	o be totally	disabled	
	Signature of Physician			Date		
Name	e of Physician:					
	cal Specialty:					
	25S:					
	hone Number: Fax					
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