UNIVERSITY OF HAWAI'I CERTIFICATION OF PHYSICIAN TO CARE FOR A FAMILY MEMBER

SECTION 1: EMPLOYEE/PATIENT INFORMATION (Employee to Complete)

Employee's Name:								
	Last,	First	Middle Initial					
Campus/School/Prog	gram:							
Patient's Name:								
	Last,	First	Middle Initial					
I hereby authorize my physician to provide the medical information as requested below in support of the 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 relative's eligibility for the Leave Sharing Program.								

Patient's Signature

Date

SECTION II: MEDICAL CERTIFICATION (Physician to Complete)

The above patient's family member is applying for Shared Leave (leave donations from co-workers and/or the Central Leave Bank) to care for the patient. 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 family member 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 the patient must be incapable of self care and require the full time assistance of a family member.

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

THE ABOVE PATIENT'S CONDITION IS:

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

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

B. If "Ye	Critical, severe, debilitating and catastrophic I certify my clinical notes support this claim: es", approximate date condition commenced:				□ No □ No		Yes Yes
	ble duration of condition: From						
Expla	in the medical finding supporting how the patient'	s health o	conditio	n meets t	he definiti	on above	
(critic	al, severe, debilitating and catastrophic in nature):						
C. If "Ye	Is incapable of self-care: I certify my clinical notes support this claim: es", approximate date condition commenced:			□ Yes			
Proba	ble duration of condition: From			_to			
Expla	in:						
D. If "Ye	Requires full time assistance of a caregiver : I certify my clinical notes support this claim: es", approximate date condition commenced:		□ No		□ Yes □ Yes		
	ble duration of condition: From						
Is the	patient currently in a hospital, hospice or care faci	lity:	□ No		□ Yes		
Expla	in why the patient requires a full time caregiver: _						
E.	To my knowledge, the patient needs the abov primary caregiver: □ No □ Yes	e named	family	member	r's assistai	nce as the	e
from a	fy that the above-information is complete and accu an illness or injury that is life threatening or critica incapable of self-care, and requires full time assis ims.	l, severe	, debilita	ating and	catastroph	nic in natu	ure,
	Signature of Physician		_		D	ate	
Name	of Physician:						
	cal Specialty:						
	255:						
	hone Number:						
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