Dallas County

Catastrophic Leave Pool Medical Certification Form

To Be Completed By Employee *(Provide Job Description to Attending Physician)*

Employee #: Employee Name:

Date: / / Contact #

Department Name:

I, authorize the Dallas County Catastrophic Leave Pool Administrator and/or designated representative to communicate with my Physician, via phone, fax or other secure electronic means and will provide a completed Authorization to Disclose Protected Health Information, found at https://www.texasattorneygeneral.gov/files/agency/hb300_auth_form.pdf.

To Be Completed By Attending Physician or Specialist (if referred)

Illness or injury:

Diagnosis:

Employee: **Date: / /**

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<table>
<tr><th colspan="3">(Answer after reviewing statement from employer of essential functions of employee's positions, or, if none provided, after discussing with employee)</th></tr>
<tr><td>Is this considered a catastrophic illness/injury?

A catastrophic illness or injury is a serious debilitating illness, injury, impairment, or physical or mental condition that is:
1. terminal, life-threatening, and/or very severe; and
2. present for a minimum of thirty (30) consecutive calendar days; and
3. forces the employee to exhaust all of his/her accrued leave and involves:
a. A period of illness or injury or treatment connected with inpatient care (e.g. overnight stay) in a hospital, hospice, or residential medical care facility for ten (10) or more consecutive days; OR
b. A period of illness or injury requiring absence from work of ten (10) or more consecutive work days, and that also involves continuing treatment by (or under the supervision of) a licensed physician; OR
c. A period of illness or injury that is long-term due to a condition for which treatment may be ineffective (e.g., stroke, terminal disease, etc.) and requires absence from work for ten (10) or more consecutive work days; OR
d. An absence of at least ten (10) consecutive work days to receive multiple treatments (including any period of recovery there from) either for restorative surgery after an accident or other injury, or for a chronic condition, e.g., cancer or kidney disease.</td><td>☐ Yes.</td><td>☐ No. If No, STOP HERE. The condition(s) does not qualify for Catastrophic Leave.</td></tr>
<tr><td>Is the condition arising out of a Workers Compensation injury (on-the-job injury)?</td><td>☐ Yes. If Yes, STOP HERE. The condition(s) does not qualify for Catastrophic Leave.</td><td>☐ No.</td></tr>
<tr><td>Is the condition arising out of elective cosmetic surgery or procedure, including weight loss surgery?</td><td>☐ Yes. If Yes, STOP HERE. The condition(s) does not qualify for Catastrophic Leave.</td><td>☐ No.</td></tr>
<tr><td>Is the condition stress related?</td><td>☐ Yes. If Yes, STOP HERE. The condition(s) does not qualify for Catastrophic Leave</td><td>☐ No.</td></tr>
</table>

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(Answer after reviewing statement from employer of essential functions of employee's positions, or, if none provided, after discussing with employee)		
Is the condition arising out of a serious complication from pregnancy that requires hospitalization of the employee for ten (10) or more days?	☐ Yes.	☐ No. If No, **STOP HERE**. The condition(s) does not qualify for Catastrophic Leave.
Is the request for any of the following: carpal tunnel syndrome, minor surgery with no complications, a broken limb, weight loss surgery or treatment, or cold, flu, or allergies, addiction treatment (including drug or alcohol rehab treatment), bereavement, birth of a child w/o complications.	☐ Yes. If Yes, **STOP HERE**. The condition(s) does not qualify for Catastrophic Leave.	☐ No.
Is the request for any of the followings: catastrophic injury with another employer, a disability under ADA that would render the employee incapable of performing the essential functions of their job even with a reasonable accommodation.	☐ Yes. If Yes, **STOP HERE**. The condition(s) does not qualify for Catastrophic Leave.	☐ No.

Date Condition Commenced:		Probable Duration of Condition	

Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment, if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.

Will the employee 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:

Will the employee be able to work part-time or on a reduced schedule because of his/her catastrophic illness or injury? ☐ Yes ☐ No

Estimate the part-time or reduced work schedule the employee needs due to the catastrophic illness or injury, if any:

______Hour(s) per day, ______ days per week from ___________(beginning date) through _____________ (ending date).

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(Answer after reviewing statement from employer of essential functions of employee's positions, or, if none provided, after discussing with employee)

If the employee's leave is required to care for an eligible family member with a catastrophic illness or injury, what are the patient's needs involving the employee? (check all that apply)

☐ Medical assistance ☐ Psychological support ☐ Transportation ☐ Assistance with activities of daily living
☐ Other,
Explain:____

Will the employee be able to work part-time or on a reduced schedule because of the catastrophic illness or injury of the eligible family member?
☐ Yes ☐ No

Estimate the part-time or reduced work schedule the employee needs due to the catastrophic illness or injury of the eligible family member, if any:
____Hour(s) per day, ______days per week from _________ (beginning date) through __________ (ending date).

By Primary Physician or Practitioner

Signature:	**Print Name:**
Date:	
Type of Practice (Specialization, if any):	
Business Address:	
Phone:	**Fax:**

By secondary health services provider, if referred by Physician/ Practitioner (Print/Sign Below)

Signature:	**Print Name:**
Date:	
Type of Practice (Specialization, if any):	
Business Address:	
Phone:	**Fax:**

Dallas County
Human Resources/Civil Service Department
500 Elm Street, Suite 4100
Dallas, Texas 75202
(Fax) 214.751.5716