Cuesta College Federation of Teachers AFT Local 4909

Strength Through Unity

Physician's Verification of Catastrophic Illness

Employee Name: _____ Patient Name (if different): _____

Patient Birth Date: _____ Relationship to Employee: _____

To the Physician:

An employee of the San Luis Obispo County Community College District (Cuesta College) has applied for a "catastrophic leave" benefit as provided by California law (Education Code 87045) and administered by the Cuesta College Federation of Teachers and Cuesta College. An employee may apply for the benefit on his or her own behalf or for the purpose of caring for a member of the employee's family. As part of the application process, the employee is required to provide verification of the "catastrophic illness or injury."

Please review the definition of "catastrophic illness or injury" below prior to completing and signing this form.

CCFT, Cuesta College, and physicians are required to use Education Code 87045(a)1 definition of "catastrophic illness or injury" for the purposes of applying for leave credit donations. The 1994 Code defines these as

> "an illness or injury that is expected to incapacitate the employee for an extended period of time, or that incapacitates a member of the employee's family which incapacity requires the employee to take time off from work for an extended period of time to care for that family member..."

A physician is required to apply the standard medical definition of "incapacity" to the patient's medical condition.

Physician's Certification:

As the physician who is responsible for the care of the patient named above, I certify it to be my medical opinion that the patient's condition satisfies the definition of the law in order to be considered a "catastrophic illness or injury" (see definition above). In the circumstance where the patient is a member of the employee's family, I further certify that the patient's condition requires that the employee take time off from work to care for the family member.

Physician, please show the **date** the illness or injury began and **describe** the nature and extent of the catastrophic illness or injury (attach supporting documentation, if necessary):

_____

_____

It is my medical opinion that the patient will be able to return to work (or the employee will no longer be required to care for the family member) as of _____.

Date (not to exceed 12 months from today's date)

_____ _____

Physician's Signature Today's Date

_____ _____

Physician's Printed Name Business Street Address or P.O. Box

_____ _____

Physician's Telephone Number Business City, State ZIP

Faculty member: make a copy for yourself. Return this signed form and all appropriate documentation to Heather Tucker, CCFT Catastrophic Leave Bank Oversight Committee Chairperson, c/o Nursing & Allied Health Division, P.O. Box 8106, San Luis Obispo, CA 93403-8106.

CCFT Use Only:
Date Rec'd: _____ Verified by: _____

This document, and any supporting documents, shall be treated as a confidential medical record(s); it shall not be placed in the employee's personnel file. Only those individuals with a need to know information will be given access to it. Any employee who fails to appropriately safeguard the confidentiality of this information will be subject to disciplinary action.

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Authorization Form for Release of Medical Records and Information

A. Identification: This document authorizes the use and/or disclosure of confidential protected health information about the following person or their authorized relative as allowed by this policy:

Employee Name: _____

Patient Name (If different from above): _____ Date of Birth: _____

B. Directions for Release:

I authorize the individual or company identified below in Section B. 1b to release and/or use protected health information pertaining to the individual listed in Section A as "Patient" to the individual(s) identified in Section B. 1a.

B. 1a. **I authorize the disclosure of information to**:

Cuesta College Human Resources Department

Members of the CCFT Catastrophic Leave Bank Oversight Committee

B. 1b. **I authorize the obtaining of information from**:

_____ (Specify Health Care Provider)

B.2 **Information to be released**: I authorize the disclosure and/or use of any information from my medical records relating to the condition(s) for which I am seeking leave.

B.3 **Purposes**: I authorize the disclosure and/or use for the following reason:
To determine my eligibility for participation in the CCFT Catastrophic Leave Bank benefit and for the disbursement thereof.

C. Right to Revoke: I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance upon it. This authorization will expire one year after the date it is signed. To revoke the authorization, I must contact, in writing, Heather Tucker, Chair, CCFT Catastrophic Leave Bank Oversight Committee, c/o Nursing & Allied Health Division, P.O. Box 8106, San Luis Obispo, CA 93403-8106.

D. Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions in Section B. I understand that this information is voluntary, the information to be disclosed is protected by law and the disclosure will conform with my directions.

I have read the contents of this authorization and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____	_____	_____
Your Signature	Printed Name	Date Signed