



Verification of Eligibility for Catastrophic Leave Donation Program

This form is to be used to request participation in a Catastrophic Leave Donation Program.

Instructions: Read the guidelines, and sign and date the request for participation. The employee should then give the form to the treating physician for completion of the physician verification section. The form is to be returned to Human Resources Management, Welch Hall C495; faxes are also accepted to (310) 217-6947. Questions may be directed to Brian Cummins, Benefits Manager, (310) 243-3771. Individuals in need of a telecommunications relay service may contact the California Relay Service at (877) 735-2929 TTY.

CATASTROPHIC LEAVE DONATION GUIDELINES

The Catastrophic Leave Donation Program is intended to provide a recipient employee donated leave credits. To qualify for the Catastrophic Leave Donation Program, the recipient employee must have a catastrophic illness or injury that has totally incapacitated the employee from work, or have an immediate family member who is totally incapacitated due to illness or injury which requires the employee's assistance. The recipient employee must be on a qualifying leave of absence, and request participation in the Catastrophic Leave Donation Program in order to request and receive donations. Full details regarding this program can be found at the following website: http://www.csudh.edu/human_res/Benefits.htm.

EMPLOYEE REQUEST FOR PARTICIPATION

I have read the guidelines, and elect participation in a Catastrophic Leave Donation Program. I hereby authorize the treating physician to release the required information below to CSU, Dominguez Hills for purposes of determining my eligibility for participation in the Catastrophic Leave Donation Program.

This catastrophic leave donation program request is for: Self Immediate Family Member

If approved, please distribute: Campus-wide or I will self-solicit donations

 Employee Name (Please Print)

 Employee Signature (or Agent)

 Date

 Patient's Name (if Family Member)

 Patient's Relationship to Employee

PHYSICIAN CERTIFICATION

NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT THE CONSENT OF THE PATIENT.

As the treating physician of the above named employee/employee's immediate family member, I hereby certify that the employee/employee's immediate family member has a catastrophic illness or injury which is totally incapacitating as defined in the above guidelines: Yes No

First date of disability (or first day employee missed work to care for incapacitated family member)

Was/will be: _____ Estimated date of return-to-full duty: _____

 Signature of Treating Physician

 Type of Practice

 Telephone Number

Address _____ Date _____

Human Resources Use: Verified by Employee Benefits _____ Date _____

Signature: _____ Date _____

Manager, Benefits and Workers' Compensation