Iowa State University
Donated Leave Catastrophic Illness/Injury for Employee
Application

***DEFINITION** – "Catastrophic Illness" means a physical or mental illness or injury, as certified by a licensed health care provider that will result in the inability of the employee to report to work for more than 30 work days on a consecutive basis.*

Part A: Completed by the Employee (Please Print or Type)

Name of Employee: _____ ISU Employee ID: _____

Department Contact: _____ Employee Phone Number: _____

Last Day Worked: _____ Last Day in Pay Status: _____

Are you:

- Currently enrolled in Long Term Disability Insurance Coverage? Yes _____ No _____
- Currently receiving Workers' Compensation Benefits? Yes _____ No _____
    - If yes, employee may not supplement workers' compensation to the extent that it exceeds more than 100 percent of the emlpoyee's pay for his or her regularly scheduled work hours on a pay-period by pay-period basis.

I certify that I have read and understand the definition of "Catastrophic Illness/Injury" as stated above.

_____ _____
Signature of Employee Date

Part B: Completed by the Treating Health Care Provider – *This information is for the purpose of determining if employee is eligible for donated leave. If not fully completed when this form is returned, no donated leave will be provided to the employee above.*

1. In your opinion does the employee meet the definition of "Catastrophic Illness" pursuant to the above definition? Yes ___ No ___
If **NO,** sign and date this form and return to the employee. If **YES,** proceed to the following questions (if more space is needed, please attach an additional sheet).

2. Diagnosis: _____
_____

3. Method of Treatment: _____
_____

4. Has employee been confined to a hospital? Yes ___ No ___ Hospital Name: _____

5. Prognosis: _____

6. Will employee be required to be absent from work on a continuous period? _____

7. Anticipated medical release to return to work date: _____

Health Care Provider's Name (**Please Print**): _____ Phone Number: _____

Health Care Provider's Signature: _____ Date: _____

Return to University Human Resources, Benefits Office:
E-mail: benefits@iastate.edu
Fax: 515-294-8226
Mail: Iowa State University, University Human Resources, Benefits Office, 1218 Madden Building, 2221 Wanda Daley Drive, Ames, IA 50011
Notification of Approval to Department and Employee: _____ Notification of Denial to Employee: _____