Iowa State University
Donated Leave Catastrophic Illness/Injury
Immediate Family Member
Application

"Catastrophic Illness" means a physical or mental illness or injury of an immediate family member (the employee's spouse/partner, parent, son, or daughter, as defined in the Family and Medical Leave Act of 1993), 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 due to the need to attend to the immediate family member 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 _____

Name of Immediate Family Member: _____Relationship: _____

I certify that I have read and understand the definition of "catastrophic illness/injury" as stated above. I further certify the condition of my family member meets the definition of "catastrophic illness/injury."

_____ _____
Signature of Employee Date

PART B: Completed by the Treating Health Care Provider - *This information is for the purpose of determining immediate family eligibility for the Donated Leave for Catastrophic Illness Program. 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's immediate family member 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, attach an additional sheet):

Diagnosis: _____
_____

2. Method of Treatment: _____
_____

3. Has your patient been hospital confined? Yes ___ No ___ Hospital name: _____

5. Prognosis: _____

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

7. Anticipated medical release of immediate family member? _____

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, 3810 Beardshear, Ames, IA 50011
Notification of approval to Department and Employee: _____ Notification of Denial to Employee: _____