

Certification of Medical Condition

Application to Use Sick Leave Pool Credits

Statement from Employee to Licensed Medical Practitioner

I am making application for sick leave to the University of Florida Sick Leave Pool because of my illness or injury. I authorize any licensed medical practitioner who examines me to release the information from the examination report and any other pertinent facts concerning my condition to appropriate University of Florida Sick Leave Pool representatives or physicians.

Signature of Patient/Designated Representative

Date

Name of Patient: _____

UFID #: _____

Instructions for the Licensed Medical Practitioner

The University of Florida Sick Leave Pool grants sick leave hours for catastrophic illnesses or injuries—catastrophic illness or injury, as defined by the pool, is a severe condition or combination of conditions affecting the mental or physical health of an employee that has resulted in a life-threatening condition or has had a major impact on life-functions. Your patient, listed above, has applied to the Sick Leave Pool for benefits. A committee of university employees will review his/her application to determine if the request meets the definition of catastrophic illness or injury. This Certification of Medical Condition is crucial in making that determination. Your careful response to each question below would be greatly appreciated.

Licensed Medical Practitioner's Name: _____

Name of Medical Practice (if appropriate): _____

Mailing Address: _____

City: _____ State: _____ Phone Number: (____) _____

Date you first examined patient for this condition: _____

Please provide information about the nature of the illness or injury, a recap of all relevant medical history, the type of treatment prescribed, and a prognosis for recovery and ability to return to work (or attach applicable notes): _____

Name of Patient: _____ UFID #: _____

How does the patient's condition qualify as catastrophic (as defined above)? _____

Please state specific medical restrictions: _____

Anticipated date patient will be able to return to work: Limited Duty: _____ Full duty: _____

Licensed Medical Practitioner's Signature

Date

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