Murrieta Valley Unified School District

Catastrophic Leave – Request and Verification Form

#1-6 To be completed by <u>Medical Provider and Employee</u>

1. Employee Name: _____
2. Patient's Name (if other than employee): _____
   Patient's Relationship to Employee: _____
3. Date medical condition or need for treatment commenced [NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT CONSENT OF THE PATIENT]: _____
4. Probable duration of medical condition or need for treatment: _____
5. If the certification is for the catastrophic health condition of the employee's family member, please answer the following:
   a. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? ____Yes ____ No
   b. After review of the employee's signed statement (see item 7 below), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.) ____Yes ____ No
6. Estimate the period of time care is needed or during which the employee's presence would be beneficial:
   _____

Printed Name of Health Care Provider: _____

_____ _____
Signature of Health Care Provider Date

<u>ITEM 7 IS TO BE COMPLETED BY THE EMPLOYEE REQUESTING CATASTROPHIC LEAVE TO CARE FOR AN IMMEDIATE FAMILY MEMBER.</u>

7. When family care leave is needed to care for a seriously ill family member, the employee shall state the care the employee will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule:
   _____
   _____
   _____

_____ _____
Signature of Employee Date