State of Mississippi Donated Leave Program
Mississippi Department of Education

PHYSICIANS' CERTIFICATION FORM

Part A. To Be Completed by the Employee

Employee Name/Print	SSN	Phone#
Department	Address	City, State Zip Code

Part B. To Be Completed by the Physician

Definition: Catastrophic injury or illness means a life-threatening injury or illness of an employee or a member of an employee's immediate family, including only a spouse, parent, step-parent, sibling, child or stepchild, which totally incapacitates the employee from work, as verified by a licensed physician, and forces the employee to exhaust all leave time earned by that employee, resulting in the loss of compensation for the employee. Conditions that are short-term in nature, including, but not limited to, common illnesses such as influenza and the measles, and common injuries are not catastrophic. Chronic illnesses or injuries, such as cancer or major surgery, which result in intermittent absences from work and which are long-term in nature and require long recuperation periods, may be considered catastrophic.

1. In your opinion does the employee meet the "Catastrophic injury or illness" definition as described above? ◯ Yes ◯ No If yes, please describe in detail, diagnosis description and if applicable, method of treatment and probable duration of condition. (Attach additional sheet if more space is needed)_____

2. Date patient was first diagnosed with catastrophic injury or illness:

3. Has the patient been hospital confined? ◯ Yes ◯ No If yes, provide hospital name and admittance date:_____

4. Anticipated date that employee will be able to return to work?

Physician's Name: _____ _____
(Please Print) Specialization

Address: _____

Physician's Signature: _____ Date: _____
{Please do not use stamp or Designee Signature)

Part C. To Be Completed by the Employee or Person acting on behalf of the Employee

I understand that the information requested on this Physician's Certification of Catastrophic Injury or Illness Form is for the use of determining my eligibility to participate in the State of Mississippi Donated Leave program. Failure to provide all of the requested information will result in my request not being processed or approved. Further, I am aware that any medical information provided will remain confidential and will not be shared with other employees in the Office of Human Resources, my Department or elsewhere within the Department of Education. If I am acting on behalf of the employee patient, I am providing documentation as having Power of Attorney, which is attached to this form.

Employee/Patient Signature	Date
Print Name of Person acting on behalf of Employee/Patient	Date
Signature of Person acting on behalf of Employee/Patient	Date