Los Rios Community College District
EXTENDED CATASTROPHIC LEAVE
PHYSICIAN STATEMENT
Los Rios Faculty

Instructions:

- *Complete Employee Information.*
- *Submit to medical provider for certification.*
- *Attach original to*

Employee Information

Employee Name:	Employee ID Number:

I hereby authorize the attending physician to furnish certification of the medical illness or injury and provide the necessary information to my employer to verify my need to access Extended Catastrophic Leave.

_____

Employee Signature Date

Physician's Statement

Please complete the following information for the above employee. The employee cannot access the Extended Catastrophic Leave until this form is completed and returned. (Note: Specific and detailed confidential patient information is not required.)

I hereby certify that the above patient has a catastrophic illness or injury that is expected to incapacitate the employee from work. Based on the severity of the medical condition, I recommend that the above patient be granted catastrophic leave from work. The expected duration of this leave is from { } to { }, but this may be subject to change based on the patient's response to treatment.

_____ _____

Physician's Signature☐ Date

Print or Type Physician's Name:	Telephone Number:

Above information may be provided on Physician's own form