Los Rios Community College District
CATASTROPHIC ILLNESS OR INJURY LEAVE MEDICAL CERTIFICATION

Instructions:

- *Complete Employee Information.*
- *Submit to medical provider for certification.*
- *Attach original to Application for Catastrophic Illness or Injury Leave Form.*
- *Please print using blue or black ink pen.*

Employee Information

Employee Name:	Employee ID Number:	Employee Home Telephone:
Employee Address:	Employee City & Zip Code:	
Employee College Name and Department:		

Request for self	I hereby authorize the attending physician to furnish certification of the medical illness or injury and provide the necessary information to my employer for the purpose of verifying my need to participate in the Catastrophic Illness or Injury Leave Program. _____ Employee Signature Date

Request for incapacitated member of family	Name:	Relationship:
I hereby authorize the physician to furnish certification of the medical illness/injury and provide necessary information to Los Rios for the purpose of verifying the need of employee named above to participate in the Catastrophic Illness or Injury Leave Program. _____ _____ Family Member Signature (*or parent/guardian if family member under 18*) Date		

Physician's Statement

Please complete the following information for the above employee or family member. The employee is not able to participate in the Catastrophic Illness or Injury Leave Program until this form is completed and returned. (Note: Specific and detailed confidential patient information is not required.)	
Nature of injury/illness:	
Estimated duration of illness/injury:	Projected return to work date:
I hereby certify that the above statements truly describe the patient's illness or injury and the estimated duration thereof. _____ _____ Physician's Signature Date	
Print or Type Physician's Name:	Telephone Number:

Above information may be provided on Physician's own form