TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER.
EL PASO

Completion of this form is only required if the employee is requesting Sick Leave from the Sick Leave Pool.

Employee Name __ ______________________________ Employee R# ______________________

My signature authorizes my health care provider to submit paperwork directly to Texas Tech University Health Sciences Center.

______________________________ ______________________________
Employee Signature Date

For Completion by Health Care Provider

Answer, fully and completely, all applicable parts. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient to determine if Sick Leave Pool criteria is met.

Please be sure to sign the form at the bottom of this page.

MEDICAL FACTS

Conditions eligible for Sick Leave Pool awards must be considered catastrophic. For purposes of Sick Leave Pool, pregnancy and elective surgery are not considered catastrophic conditions, except when life-threatening complications arise from them.

1. Does the patient's condition require an absence from work and/or treatment for at least 45 continuous calendar days **AND**
   Qualify under any of the following? ☐ Yes ☐ No **If yes, check all that apply:**

   ☐ A life threatening condition

   ☐ Mental, behavioral, or physical health condition that causes patient to be incapable of self-care

   After review of the employee's position description, the condition has been determined to be severely Debilitating condition that will result in the individual not meeting the essential functions of his/her job

If No, the condition(s) does not apply for an award of Sick Leave Pool. The employee may still qualify for FMLA.

2. Describe other relevant facts, if any related to the condition for which the employee seeks an award of Sick Leave Pool (such facts may include symptoms, medication, or any regimen of continuing treatment, e.g. radiation or chemotherapy appointments):

PHYSICIAN'S INFORMATION

Name ______________________________ Phone Number ______________________________

Address ______________________________ Fax Number ______________________________

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______________________________ ______________________________
Physician Signature Date

Attacment J