UNT | SYSTEM
BUSINESS SERVICE CENTER

Sick Leave Pool Physician's Certification

I authorize my licensed practitioner_____to release the information requested on this form, and/or any additional relevant information concerning my health condition, to the Sick Leave Pool Administrator.

Patient's Printed Name:_____

Patient's Signature:_____Date:_____

Employee's Printed Name (if different than Patient's Name):_____

To be completed by licensed practitioner:

The employee identified above has applied for the University's sick leave pool benefits. The information requested will be used solely to determine the employee's eligibility for benefits and, if eligible, the number of days awarded to the employee.
1. What is your diagnosis of the severe condition or combination of severe conditions affecting this patient?
2. Is this treatment considered elective? _____yes_____no
3. Will this severe condition or combination of severe conditions result in death if not treated promptly? _____Yes_____No. If yes, please explain:
4. Has this severe condition or combination of severe conditions required hospitalization for more than 72 consecutive hours? _____Yes_____No If yes, please provide dates:
5. Is the patient's condition a catastrophic illness or injury, which is defined as a severe condition or combination of conditions affecting the mental or physical health of the employee that requires the services of a licensed practitioner for a prolonged period of time? _____Yes_____No. If yes, what is the probable duration of severe condition or combination of conditions?
6. How long will the severe condition or combination of conditions prevent our employee from working? _____Days_____Months
Licensed Practitioner Signature:
Print Name: Date:
Office telephone #: Office fax #:
Office Address:

Send completed form to: University of North Texas System Business Service Center, ATTN: Human Resources Dept., 1112 Dallas Drive, Suite 400, Denton, TX 76205 or fax to: 940/369-5599.