**For Employees at All Locations: UNT, UNTHSC, UNT Dallas, UNT System Administration**

# 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:

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| *The employee identified above has applied for 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. Has this condition been designated as terminal? _____yes_____no |
| 4. Will this severe condition or combination of severe conditions result in death or is it a severely debilitating condition that will result in the individual not meeting the essential functions of their job if not treated promptly or at regularly scheduled intervals (e.g. chemotherapy treatments, radiation treatments, etc.) _____Yes_____No. If yes, please explain: |
| 5. Has this severe condition or combination of severe conditions required hospitalization for more than 72 consecutive hours? _____Yes_____No If yes, please provide dates: |
| 6. 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? |
| 7. Will this condition require an absence from work for at least 45 continuous calendar days? _____yes_____no If yes, please give the total: _____Days_____Months |
| Licensed Practitioner Signature: |
| Print Licensed Practitioner Name: Date: |
| Office telephone: Office fax: |

| Office Address: |
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| |

**Send completed form to:**

**University of North Texas System Human Resources**

**ATTN: Benefits**

**3500 Camp Bowie Blvd, EAD**

**Fort Worth, Texas 76107**

**Secure fax: 817-735-0127**