Catastrophic Leave Bank

Medical Verification Form/Attending Physician's Report

Travis Unified School District
2751 De Ronde Drive
Fairfield, CA 94533-9710

Employee Name: ____________________________ Position: ______________ Site: _____________

Address: ____ Home/Cell Phone: _______________

TO BE COMPLETED BY THE PHYSICIAN: The employee noted above is requesting that s/he be granted catastrophic leave. This request will be considered by a committee of fellow employees who represent the contributors to the Catastrophic Leave Bank. The information requested below will be used to determine the employee's eligibility for this leave and shall remain confidential.

Patient Name: ____

Diagnosis and Current Status:

Prognosis:

If the leave is to care for a family member, what factors or conditions exist which require the presence of the employee? How long do you anticipate the employee's presence will be required to provide the necessary care?

Is it possible for the above named employee to work part-time? YES / NO

Please provide any information pertinent to the application which should be considered by the Committee. Additional pages may be used.

____________________	____________________	____________________
Physician's Signature	Date	Phone number
____________________	____________________	____________________
Physician's Printed Name	Street Address	City, State, Zip code

RETURN THIS FORM TO:

TRAVIS UNIFIED SCHOOL DISTRICT
Human Resources
ATTN: Catastrophic Leave Bank Committee
2751 De Ronde Drive
Fairfield, CA 94533-9710
Phone: 707.437.4604
Fax: 707.437.8122 (send C/O Human Resources)