**Georgetown Independent School District**
**CATASTROPHIC LEAVE**
**ATTENDING PHYSICIAN'S STATEMENT**

Complete the Employee Information portion below. The attending physician must fully complete the remainder of the form. A request for catastrophic leave days will **not** be considered until the **Attending Physician's Statement** is received.

**Employee Information:**
Employee Name:_____ SS Number: _____
Campus/Dept._____ Date:_____
Patient's Name:_____ Relationship to GISD Employee:_____

**Attending Physician:**
Please complete the following information regarding the patient named above.
Describe illness or injury in detailed, lay terms:_____
_____
_____

Date of diagnosis:_____

Is the patient's illness, injury, or condition life threatening? Yes_____ No_____

Name of Attending Physician:_____
Address:_____
Phone: (_____)_____ Fax:_____

Explain the short-term prognosis:_____
_____

Explain the long-term prognosis:_____
_____

Dates of treatment:_____ Is patient still under your care? _____

**Hospitalization:**
Name and address of hospital:_____
_____
Date admitted:_____ Date discharged:_____ Is this condition due to pregnancy?_____

**Answer Only if the Patient is a Georgetown ISD Employee:**
As you understand this patient's job responsibilities, and based on your professional assessment of the patient's current condition, can you recommend this person to return to work at this time to perform his/her regular job assignment? ☐ Yes ☐ No
If the answer is no, what is the anticipated date of return to work?_____

I certify that the information given on this Attending Physician's Statement is accurate and true.

Physician's Signature:_____ Date:_____

**Please return the completed Attending Physician's Statement to:**
**Georgetown ISD • Attn: Human Resources Department**
**507 E University Ave • Georgetown, TX 78626 • Fax (512) 943-1894**

**For HR Department Use Only**
**☐ Yes ☐ No** **Date Received**_____

CATASTROPHIC LEAVE
REQUEST FOR CATASTROPHIC LEAVE

Please complete this form and return to the Human Resources Department. An official **Attending Physician's Statement** must also be on file before this request can be considered.

Catastrophic leave benefit shall be used only for the catastrophic illness or disability of the employee, the serious health condition of the employee's parent, spouse, or child.

Employee Name: _____
Address: _____
Telephone: _____ Campus/Dept.: _____ Date: _____
SS Number: _____ Position: _____
Patient's name if different than above: _____ Indicate relationship: _____

I have or will have used all my available state and local leave, as well as any compensatory time and vacation days, as applicable.

I am requesting leave: Begin: _____/_____/_____ End: _____/_____/_____
mo day yr mo day yr

Nature of illness or injury: _____
_____
_____
_____

Date illness began or accident occurred: _____Date physician consulted: _____

Name, address and phone number of attending physician: _____
_____
_____

Did the condition require hospitalization? Yes: _____ No: _____
If yes, please complete the following information:

Name of hospital: _____

Dates of confinement: _____

Is this condition eligible for Workers Compensation? _____

**I certify that the information given on this request for catastrophic leave is accurate and true.**

Signature of Employee: _____ Date: _____

**For HR Department Use Only**
Date Received: _____
Employee Member of Catastrophic Leave Pool? Yes _____ No _____
Date Decision Communicated to Employee: _____ Granted _____ Denied _____