Santa Maria Joint Union High School District
MEDICAL PROVIDER CERTIFICATION
CATASTROPHIC LEAVE PROGRAM

TO THE MEDICAL PROVIDER:

The employee of the Santa Maria Joint Union High School District whose name appears on the attached Catastrophic Leave Request has applied for a "catastrophic leave" pay-continuation benefit as provided by California law (Education Code S44043.5). An employee may apply for the benefit on the employee's own behalf, or for the purpose of caring for a member of the employee's family.

Before the catastrophic leave request may be granted, the employee is required to provide a verification of the "catastrophic illness or injury" in the form of a medical provider certification. Please review the relevant portion of the definition cited below prior to completing and signing this certification.

> Catastrophic illness or injury is defined [Education Code §44043.5(a)(1)] as "an illness or injury that is expected to incapacitate the employee for an extended period of time, or that incapacitates a member of the employee's family which incapacity requires the employee to take time off from work for an extended period of time to care for that family member . . ."

The medical provider is required to apply the standard medical definition of "incapacity" to the employee (or employee's family member's) medical condition.

Employee Name:_____ Date of Birth:_____

Patient Name: _____ Date of Birth:_____

MEDICAL PROVIDER CERTIFICATION: (Please check and complete each statement that applies)

☐ As the provider who is responsible for the care of the above-named patient, I certify it to be my medical opinion that the patient's condition satisfies the definition of the law in order to be considered a "catastrophic illness or injury".

It is my medical opinion that the patient will be able to return to work as of:_____

☐ The patient is a member of the employee's family. I certify it to be my medical opinion that the patient's condition satisfies the definition of the law in order to be considered a "catastrophic illness or injury". I further certify that the patient's condition requires that the employee take time off from work to care for the family member.

It is my medical opinion that the employee will no longer be required to care for the family member and will be able to return to work as of: _____

Nature of Illness or injury: _____

Medical Provider's Name:_____ Phone:_____

Medical Provider's Signature:_____ Date:_____