University HOSPITAL
Newark, NJ

Human Resources Confidential

PATIENT AUTHORIZATION and PHYSICIAN/HEALTH CARE PROVIDER CERTIFICATION

I. ***PATIENT AUTHORIZATION:***

I, _____, am an employee or immediate family member of an employee of University Hospital. I am seeking eligibility to receive leave time donations under the Hospital's Staff Leave Donation Program. *(**The Staff Leave Donation Program** permits staff members, who meet qualifying criteria, and who are in critical need of extending paid leave prior to commencing an unpaid medical leave due to a documented life-threatening or catastrophic condition for themselves or immediate family members, to receive leave time donations from employees).*

I, _____, hereby authorize my physician/health care provider to provide and describe the medical facts that support his or her assessment that my illness or the illness of a qualifying family member is life-threatening or a catastrophic condition. Furthermore, I authorize my physician/health care provider to speak with a University Hospital representative who may have a need to clarify any uncertainty concerning the Patient Authorization and Physician/Health Care Provider Certification executed below.

_____ _____
Employee's Signature **Date**

II. ***PHYSICIAN HEALTH CARE PROVIDER CERTIFICATION:***

Please review the following guidelines which must be met prior to the transfer of donation time. All requests must comply with the Recipient and Donor Criteria and Requirements indicated in the Staff Leave Donation Program Policy. While the clinical/diagnostic information you may have already provided is appreciated, this office is not in a position to appropriately assess whether this is life-threatening or catastrophic condition. Therefore, it is requested that you complete the following:

1:_____ currently has a life-threatening or catastrophic condition which is defined as follows: ***Life-threatening or catastrophic condition***: *An illness, injury, impairment, or physical or mental condition that a licensed physician or certified/licensed health care provider certifies as life threatening or terminal.* (Please indicate the patient's condition by filing in the name.)
AND

2:_____ is the projected length of time of illness/condition. (Please give an approximate end date.)
AND

3: The following medical facts support my conclusion that my patient has a life-threatening or catastrophic condition as defined above:_____

_____

_____

OR

4:_____ **is not** currently in a life-threatening or catastrophic condition as defined above.

I certify that the above indicated patient is under my care and that the foregoing reflects my assessment of his/her condition.

_____ _____ _____ _____
Physician's name – Print **Physician's Signature** **Date** **Telephone No.**

Return Form To:
Darnell Reamer, Manager EEO Leaves & Labor Relations
Department of Human Resources
Email the form to: myloa@uhnj.org