ALCORN STATE UNIVERSITY
Alcorn State, Mississippi
Medical Certification Form for Donated Leave

Section I

Employee Name: _____ SSN: _____

Name of Eligible Family Member Requiring Employee's Absences (if other than employee):
_____

Relationship to Employee: _____

Date(s) Leave Requested: _____

_____ _____
Employee's Signature (or Personal Representative) Date

(Note: Eligible family member means: spouse, parent, step parent, sibling, child or stepchild.)

To be completed by Doctor or Health Care Provider:

Section II
Doctor or Health Care Provider Certification

(Note: Catastrophic injury or illness is defined as a life threatening injury or illness which totally incapacitates the individual or the employee from work.)

Is this illness or injury considered catastrophic? _____ Yes _____ No If "Yes" please answer the questions listed below.

	Yes	No	N/A
Is the employee able to perform the essential functions of his/her position?	❑	❑	❑
Is it necessary that this employee be absent to care for a family member?	❑	❑	❑
Is intermittent leave or a reduced work schedule medically necessary?	❑	❑	❑

Date illness began: _____ Estimated length of illness: _____

Please describe the treatment/prognosis required for the employee or family member. _____

_____

_____

In your professional opinion, when will the employee be able to return to work? _____

_____ _____
Signature of Doctor/Health Care Provider Date

_____ _____
Printed Name and Address of Above Telephone Number

(5/2003)