TULARE COUNTY
VACATION DONATION PROGRAM:
PHYSICIAN CERTIFICATION FORM

A) EMPLOYEE SECTION: To be completed by employee

Name____ Emp Id #_______________________
(please print)

Signature____ Dept.__________________________

Date________________________

If the vacation donation is due to a family member's condition, please provide name and relationship to yourself:

____ ____________________________
Name Relationship

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B) PHYSICIAN SECTION: To be completed by employee/family member's physician

A catastrophic illness or injury is defined as a serious illness, injury, impairment, physical, or mental condition that is present for a minimum of seven (7) calendar days, and that involves incapacity or treatment.

Please initial if applicable:

_____1. Connected with inpatient care (e.g., an overnight stay) in a hospital, hospice, or residential health care facility; or

_____2. Requiring absence of more than seven calendar days from work, and that also involves continuing treatment by (or under the supervision of) a licensed health care provider; or

_____3. Due to a chronic serious health condition (e.g., asthma, diabetes, epilepsy, etc.); or

_____4. That is long-term due to a condition for which treatment may be ineffective (e.g., stroke, terminal disease, etc.); or

_____5. To receive multiple treatments (including any period of recovery there from) either for restorative surgery after an accident or other injury, or for a chronic condition such as cancer or kidney disease".

I certify that the above named individual has a catastrophic and/or serious chronic illness or injury.

Name of Patient:____ Date Evaluated:_________________

Date of expected release from physician's care for above illness/injury:_________________

Physician's Signature:____Date:_______________

Physician's Name (Printed)____

Address:____ Telephone #__________________________