

**CARLETON COLLEGE
CATASTROPHIC LEAVE SHARING PROGRAM (CLSP)
ATTENDING PHYSICIAN'S STATEMENT**

Please Print or Type

Part A. TO BE COMPLETED BY THE STAFF MEMBER or designee

Name of Patient: _____ Date of Birth _____

Home Address: _____

Statement of Patient: In support of my application for hours from the Carleton Catastrophic Leave Sharing Program, I authorize the release of information concerning my illness/injury to Carleton's Human Resources Office.

Signature of Patient or designate Date

Definition - "Catastrophic Illness or Injury" means a physical or mental illness or injury as certified by a licensed physician, that will result in the inability of the employee to perform the essential functions of the job with or without reasonable accommodation for more than 30 work days on a consecutive or intermittent basis.

Part B. TO BE COMPLETED BY THE PHYSICIAN

Physician's
Name (Print): _____ Phone No. _____

Mailing Address _____

1. In your opinion, does the employee meet the "Catastrophic Illness or Injury" definition above?

Yes ___ No ___ (Check one) If no, sign and date this form.
If yes, answer questions 2-3.

2. Date condition commenced: _____

3. Anticipated number of days that the employee will be unable to perform the essential functions of the job with or without reasonable accommodation: _____

Physician's Signature: _____ Date: _____