State of Nevada  
University of Nevada, Reno  
Physician’s Certification for Catastrophic Leave Request

The State of Nevada’s Catastrophic Leave program allows State employees to donate excess sick or annual leave to eligible coworkers who have experienced a catastrophe and have exhausted their own paid leave balances. As per NAC 284.576, the following form must be completed in order to substantiate the need for leave.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

### Section I (to be completed by the employee):

<table>
<thead>
<tr>
<th>Employee Name: __________________________________________</th>
<th>Employee ID #: _______________________________________</th>
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<tbody>
<tr>
<td>Patient name and relationship (if patient other than employee):  ____________________________________________________________</td>
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<tr>
<td>Employee Signature: _________________________________________</td>
<td>Date: _______________________________________________</td>
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### Section II (must be completed by the attending physician):

1. a. Describe the serious illness or accident which supports the need for leave. If your patient experienced an accident, describe the medical conditions that resulted from that accident.

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

b. What is the date the serious illness commenced or the accident occurred? _______________ *(Calendar Date Required)*

2. a. Is your patient’s serious illness or medical condition "life threatening" resulting in a substantial risk of death?  

☐ No.  ☐ Yes. If yes, please explain:

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

b. Does your patient have a serious illness or medical condition requiring a convalescence which you expect to exceed 10 consecutive weeks?  

☐ No.  ☐ Yes. If yes, please explain:  

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

c. What is the first date when the employee will need to be absent from work due to a serious illness or accident? _______________*

d. What is the first date when the employee will be able to return to work? _______________ *(Calendar Date Required)*

3. Will your patient need follow-up treatment once s/he returns to work? ☐ No.  ☐ Yes. If yes, 

a. What is the nature of the follow-up treatment?

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

b. How frequently will it be required?

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

c. When do you expect your patient to complete his/her follow-up treatment (Required: date or length of time)? _______________

| Print name, address and telephone number of physician | Type of practice - field of specialty:
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<td>------------------------------------------------------</td>
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<tr>
<td>Signature of physician:</td>
<td>Date: ________________________</td>
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