



APPLICATION FOR ACCRUED TIME-OFF DONOR PROGRAM

(r. 02.13.17)



EMPLOYEE STATEMENT

I, _____, hereby request authorization to participate in the **Accrued Time Off-Donor Program**, established by MCO 350-45, due to a terminal or major catastrophic illness, as certified below. I authorize my treating physician to fill out the Physician's Statement indicated below. I understand that the City of Milwaukee reserves the right to require me to obtain, at my own expense if not covered by the health insurance provider, a second opinion from a physician of my choice as to the nature of the physician's diagnosis and prognosis contained in the physician's statement below.

Employee Signature

Date of Birth

Employee ID Number

Date Signed

PHYSICIAN'S STATEMENT

This is to certify that *(employee/immediate family member)* _____ has been under my professional care for this condition since *(date)* _____. It is my medical opinion that he/she has a LIFE THREATENING, TERMINAL OR MEDICAL CONDITION likely to result in a SUBSTANTIAL PERMANENT DISABILITY within the next year. The **diagnosis** and resulting **prognosis** for this condition is:

DIAGNOSIS:

PROGNOSIS:

Physician's Signature:

Date:

Physician's Name (please print):

Phone:

Office Address:

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 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.

FOR DER USE ONLY: **Approved** **Denied**

Maria Monteaquado, Director - Employee Relations

Date

RETURN THE COMPLETED ORIGINAL FORM TO:

Leave Administration Coordinator
City of Milwaukee, Department of Employee Relations
City Hall, 200 E. Wells St, Room 706
Milwaukee WI 53202-3515