UNIVERSITY OF ALBERTA

Compassionate Care & Emergency Leave (CCEL) Benefit
Medical Certificate to Support Application

Staff Member Name: _____ ID Number: _____

Department _____ Date: _____

TO BE COMPLETED BY TREATING PHYSCIAN

The staff member named above has made application for a leave of absence under the Compassionate Care & Emergency Leave provisions of the University of Alberta benefit plan. Information provided on this form will be kept confidential and only used to determine eligibility.

Your Patient's Name: _____

1. Relationship of the staff member to your patient _____

2. Does your patient currently have a serious medical condition or are they suffering from a catastrophic illness that has resulted in a life threatening condition and/or had a major impact on their life functions.

   Yes No

   Nature of this condition: _____

3. Does the staff member named above play a primary role in providing care or support to your patient ?(i.e. psychological or emotional support, arranging for the care by a third party or directly providing or participating in the care of the individual)

   Yes No

   Expected duration this support will be required: _____

Medical Doctor Contact Information:

Name: _____ Contact Number: _____

Specialty: _____

Hospital or clinic affiliation _____

Signature: _____