

APPLICATION FOR CATASTROPHIC LEAVE BENEFITS

Confidential

A "catastrophic illness or injury" means an illness or injury that is expected to incapacitate the employee for an extended period of time or employee's member of the immediate family which includes a spouse, natural child, adopted child, mother, father, or any immediate family member living in the employee's household who has suffered a catastrophic illness or injury which requires the employee to take time off work for an extended period of time to care for that immediate family member, and who has exhausted all other paid leave including vacation. The District may require verification of any claimed catastrophic illness or injury. The unit member must have donated a minimum of the equivalent of one work day of sick leave during the open enrollment period for the catastrophic leave program year in which the absence resulting in unit member's request for catastrophic leave first began.

I formally request that the Catastrophic Leave Committee (CLC) review the following information for acceptance of "Catastrophic Leave" benefits. I have attached all needed documentation which may include but is not limited to a doctor's verification of illness and declaration of compliance with the requirements for these benefits.

Name: _____ Date of Initial Employment: _____

Work Site: _____ Position: _____

Doctor's Name/Address/Phone:

Signature of Applicant

Date

For Office Use Only

Date Received: _____

CLC Meeting Date: _____

Approved _____

Denied _____

Notes:

