CATASTROPHIC LEAVE FORM
CONFIDENTIAL AND MANAGEMENT EMPLOYEES

Instructions: Applications must be submitted to Human Resources a minimum of ten (10) working days prior to the start date of the requested leave or as soon as possible if circumstances prevent earlier submission. Employees must include a signed and dated statement from a licensed medical provider verifying that a serious illness or injury will require prolonged treatment of either the employee or a family member per AP 7345.

A. EMPLOYEE INFORMATION: ☐ Confidential ☐ Management

Employee Name:_____ **Banner ID:A**_____

Department:_____ **Title:** _____ **Contact Number:**_____

B. IF YOU WISH TO DONATE LEAVE (Complete sections A & B and submit to Human Resources)

I understand the requirements of the Catastrophic Leave Program and I wish to donate sick leave or vacation leave as specified below. Employees may donate eligible leave credits to the "Bank" by completing the donation form, indicating the amount of sick leave or vacation time totaling a minimum of eight (8) hours they wish to donate.

I authorize the District to deduct the specified amount from my leave balance(s). I also understand that this donation is voluntary and irrevocable. All donations will be deposited to the Catastrophic Leave Bank.

☐ I wish to donate _____ **sick leave** hours ☐ I wish to donate _____ **vacation leave** hours

☐ I wish to donate to (optional): _____

Please Note: You may be eligible to use earned sick leave for service credit upon retirement. Please check with CalPERS/CalSTRS prior to making your donation.

_____ _____ _____

NAME (Print) NAME (Signature) – Authorizing Deduction Date

C. IF YOU WISH TO REQUEST CATASTROPHIC LEAVE (Complete sections A & C and submit to Human Resources)

☐ I wish to request _____ hours of catastrophic leave. Estimated duration of absence: From _____ To _____.

In accordance with Education Code Section 87045.(b) verification required: Employees must attach a signed and dated statement from a licensed medical provider verifying a serious illness or injury that will require prolonged treatment for either the employee or a family member.

_____ _____ _____

NAME (Print) NAME (Signature) Date

PAYROLL USE ONLY

Verified by: _____ Date: _____

DONATIONS:

- Donation Request: ☐ Accepted ☐ Not Accepted Comments: _____
- Number of hours deducted from: Sick Leave: _____ Earned Vacation: _____

REQUESTS:

- All accrued leave exhausted or will exhaust on: _____ ☐ Previously donated to the Catastrophic Leave Bank on: _____

HUMAN RESOURCES / CATASTROPHIC LEAVE COMMITTEE USE ONLY

Human Resources:

Date CL Form Received: _____

Committee Decision:

☐ Approved Amount of Hours: _____ ☐ Denied

Comments:_____

_____

_____ _____ _____

NAME (Sign and Date) Committee Representative

NAME (Sign and Date) Committee Representative

NAME (Sign and Date) Committee Representative

Copy Sent To: ☐ Payroll ☐ Employee ☐ Employee Medical File