CATASTROPHIC LEAVE POOL APPLICATION

A Catastrophic Event is defined as a mental or physical condition that: (a) will result in death if not treated timely, or (b) requires hospitalization for more than seventy-two (72) consecutive hours, or (c) is considered a terminal illness. *NOTE: Pregnancy and elective surgery are not considered severe conditions except when life-threatening complications arise from them.*

Employee's Name	Employee Number
Department	Office Phone

1. This application for this catastrophic leave is a result of (select one):

☐ My own serious health condition (skip to question 2)

☐ A serious health condition of an immediate family member

Provide the following information:

Name of the family member: ______________________ Relationship to the employee: ______________

State the type of care you will provide:

2. Indicate the effect of this condition on your workweek

☐ I will need continuous time off. Indicate time period, if known: ______________________

☐ I will need continuous time off. Indicate schedule and duration if known: ______________________

☐ I will need to change my regular work schedule. Explain:

3. Is this request for YOUR OWN serious health condition: Yes ☐ No ☐

4. Diagnosis: ____

5. Did the condition or combination of conditions result from an on-the-job injury. Yes ☐ No ☐
(Describe injury and date it occurred.)

4. Leave Recipient Signature

______________________________ ______________________________
Signature Printed Name

Signature of (check one): ☐ Leave Recipient ☐ Representative of Leave Recipient

Date: ____________________ Relationship of representative to employee: ______________________

HR USE ONLY: Identity of the Leave Recipient's representative verified using a picture ID by ______________________________.

5. **Department Information**: (To be completed by applicant's department)

Leave balance reviewed: ☐ Yes ☐ No Health care provider statements reviewed: ☐ Yes ☐ No

Select One: Employee and event ☐ Qualify ☐ Do Not Qualify for appeal

Comments:

Reviewer: Name ____ Title: ______________________________

Signature of Reviewer: ______________________________________

Approved for Appeal – Signature, Department Director: ____

Date: ________________________

Original to Applicant's Leave File: Copy to Leave Recipient