CATASTROPHIC LEAVE REQUEST FOR CATASTROPHIC LEAVE

Please complete this form and return to the Human Resources Department. An official Attending Physician's Statement must also be on file before this request can be considered. Consult DEC(LOCAL) for more information.

Catastrophic leave benefit shall be used only for the catastrophic illness or disability of the employee, the serious health condition of the employee's parent, spouse, or child.

Employee Name: _____

Address: _____

Telephone: _____ Campus/Dept.: _____ Date: _____

SS Number: _____ Position: _____

Patient's name if different than above: _____ Indicate relationship: _____

| have or will have used all my available state and local leave, as well as any compensatory time and vacation days, as applicable.

| am requesting leave: Begin: _____ /_____ /_____ End: _____/_____ / _____

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Nature of illness or injury:
_____
_____
_____

Date illness began or accident occurred: _____ Date physician consulted: _____

Name, address and phone number of attending physician: _____

_____
_____

Did the condition require hospitalization? Yes: _____ No: _____

If yes, please complete the following information:

Name of hospital: _____

Dates of confinement: _____

Is this condition eligible for Workers Compensation? _____

I certify that the information given on this request for catastrophic leave is accurate and true.

Signature of Employee: _____ Date: _____

For HR Department Use Only

Date Received: _____

Date Decision Communicated to Employee: _____ Granted _____ Denied _____