**APPENDIX M-2**

Catastrophic Leave Application

Ref: Article 13 Leaves of Absence and Related Matters

A “Catastrophic Illness” or “Injury” means an illness or injury that is expected to incapacitate the unit member for an extended period of time or that incapacitates a member of the unit member’s family which requires the unit member to take time off from work for an extended period of time to care for that family member, and taking extended time off creates a financial hardship for the unit member because he/she has exhausted all of his/her sick leave and other paid time off.

***Applications must be submitted to the Human Resources Department 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 FMLA form from a licensed physician verifying that a serious illness or injury will require prolonged treatment of either the unit member or a family member.***

Unit Member’s Name (Last, First):       Banner ID:

Department:       Classification:

Work Phone:       Home/Cell Phone:

I wish to request     hours of catastrophic leave for the purpose of:

[ ]  Incapacitating illness or injury to myself [ ]  Incapacitating illness or injury to a family member

Name of Family Member:       Relationship:

Estimated duration of absence (M/d/yyyy): from (start)       to (end)

I estimate I will exhaust all of my accrued leaves on (M/d/yyyy):

Unit Member’s Signature Date

*(Type in your name to acknowledge the information you are providing is true and accurate to the best of your knowledge)*

**PAYROLL USE ONLY — PAYROLL VERIFICATION:**

**All fully paid leave credits exhausted on:**

**HUMAN RESOURCES/CATASTROPHIC LEAVE COMMITTEE USE ONLY**

Date request for leave received:       Date reviewed by Committee:

[ ]  **REQUEST APPROVED** for       hours.

[ ]  **REQUEST DENIED** (provide explanation below):

CSEA 262 Representative Signature Date

*(Type in your name to acknowledge the information you are providing is true and accurate to the best of your knowledge)*

Deputy Director, Human Resources Signature Date

*(Type in your name to acknowledge the information you are providing is true and accurate to the best of your knowledge)*