REQUEST FOR CATASTROPHIC LEAVE

Visalia UNIFIED SCHOOL DISTRICT

Employee Name: _____ **Employee ID #:** _____ **HRS/Day:** _____

Work Site/Department: _____ **Position:** _____ **Phone #:** _____

☐ CERTIFICATED (VUTA) ☐ CERTIFICATED MANAGEMENT ☐ CLASSIFIED (CSEA) ☐ CLASSIFIED MANAGEMENT

I am requesting participation in the Catastrophic Leave Program for:

☐ Self (Employee) ☐ Spouse ☐ Child ☐ Parent

DATES OF LEAVE: _____ **TO** _____

In order for your request to be reviewed medical certification is required.

EMPLOYEE ACKNOWLEDGEMENT:

This request is accompanied by a written verification signed and dated by the treating physician certifying that the catastrophic illness or injury is one that incapacitates you for an extended period of time, or that incapacitates a member of your family, and requires you to take time off from work to care for that family member. The written verification must include the anticipated duration of the leave.

I understand that I must exhaust all accumulated leave, including any leave that I continue to accrue on a monthly basis, and all paid leave options, before using donations. The maximum amount of time for which donated leave credits may be used by an eligible employee may not exceed a maximum period of 65 workdays.

I understand that my name will be used in soliciting donations. No medical information will be provided in the solicitation of donations. Donations made under the catastrophic leave program are confidential.

I understand that approval of my catastrophic leave request does not guarantee I will receive pay for the duration of my leave.

Signature: _____ Date: _____

FOR HRD USE ONLY

☐ **Conversion** ☐ **Donation** ☐ **Approved** ☐ **Denied**

Comments:

_____

_____

_____

_____

Approved/Denied By: _____ Date: _____

Return Form to: Human Resources-Employee Benefits
5000 W Cypress Ave, Visalia CA 93277