PFLUGERVILLE INDEPENDENT SCHOOL DISTRICT
CATASTROPHIC LEAVE BANK
REQUEST FOR CATASTROPHIC LEAVE

Please complete both pages of this form and return to the Leave Office. An official Catastrophic Leave Bank (CLB) Attending Physician's Statement must also be on file before this request can be considered. Ordinarily, a decision should be made and communicated within 15 working days.

Name:_____

Address:_____

Telephone:_____ Date:_____

Campus/Department:_____ Position:_____

E Number:_____

I have or will have used all my available state and local leave, as well as any compensatory time and vacation days as applicable. (**Complete A and B**)

A. I am requesting catastrophic leave:

Begin:____/____/____ End:____/____/____

(Employee should have no more than 10 days of available leave, comp time and/or vacation when requesting catastrophic leave)

B. I am requesting to be <u>reimbursed</u>: Dates of absence from work related to this condition: _____

_____

_____

Still absent from work: YES NO

If still absent, anticipated return to work date:_____

Employee's relationship to the person with the medical condition:_____

_____

Explain the medical condition:_____

_____

_____

_____

Date medical condition began:_____

Date physician consulted:_____

Name, address and phone number of attending physician:_____

_____

_____

Did/Does the condition require hospitalization? YES NO

If YES: Name of hospital:_____

Dates of confinement:_____

Is this condition eligible for Workers Compensation? YES NO

Will you be eligible to draw upon your disability insurance? YES NO

If YES, give the dates:_____

I understand that in order to qualify for catastrophic leave I must qualify for FML and my leave must be designated as FML. I also understand that once I begin to use catastrophic leave, I will have exhausted all of my state/local/vacation leave days accrued. If I need to be off work for a reason not related to the above stated injury or illness my pay will be docked.

I certify that the information given on this
Request for Catastrophic Leave
Is true and correct

Employee signature:_____ **Date:**_____

PFLUGERVILLE INDEPENDENT SCHOOL DISTRICT
CATASTROPHIC LEAVE BANK
ATTENDING PHYSICIAN'S STATEMENT

Employee Information:

Employee Name:_____

E Number:_____

Campus/Department:_____ Date:_____

Patient's Name:_____

Relationship to Employee:_____

Authorization:

I hereby authorize Pflugerville Independent School District Catastrophic Leave Bank to receive from and/or provide to medically related facilities and/or insurance companies, information as to any physician and/or mental condition of myself or the person named above as patient relating to this claim.

Signature:_____

ATTENDING PHYSICIAN: Please complete the following information regarding the patient named above.

What disease or medical condition does the patient have:

_____

_____

_____

Explain any complications and procedures performed or will be performed:

_____

_____

_____

_____

_____

_____

ATTENDING PHYSICIAN'S STATEMENT *(continued)*

Explain the short-term and long-term prognosis:_____

_____

_____

Dates you treated the patient:_____

Is the patient still under your care: YES NO

Was the patient hospitalized: YES NO

If yes, name and address of hospital:_____

_____

Date Admitted:_____ Date Discharged:_____

Is this condition due to pregnancy? YES NO

Answer only if the patient is a Pflugerville ISD employee:
As you understand this patient's job responsibility, from your professional assessment of the patient's current condition, can you recommend him/her to return to work at this time to perform his/her regular assignment? YES NO

If the answer is NO, what is the anticipated return to work date?_____

Attending Physician Name:_____

Address:_____

Phone:_____ Fax:_____

Signature:_____ Date_____

Please return the completed Attending Physician's Statement to:

Pflugerville ISD
Administration Building
1401 West Pecan
Pflugerville, TX 78660
512-594-0026 phone 512-594-0031 fax
ATTN: Kristin Baum, Director of Human Resources - Risk Mgmt/Leave & Benefits