CONEJO VALLEY UNIFIED SCHOOL DISTRICT
**HUMAN RESOURCES DEPARTMENT**
750 Mitchell Road, Newbury Park, CA 91320
Phone: (805) 498-4557 ♦ Email: Jbadshah@conejousd.org

***Mark W. McLaughlin, Ed.D***
Superintendent

**Shauna Ashmore**
Assistant Superintendent, Human Resources
**Andrew Cantwell**
Director, Classified Human Resources

# Catastrophic Leave Request

In addition to filling out this leave request, you must also attach a physician's statement that must cover the dates listed below.

| | |
|---|---|
| Name: | Last 4 digits of Social Security Number: |
| Street Address: | City/State/Zip: |
| Work Phone: | Home/Cell Phone: |
| Position Title: | School/Department: |
| Date the Catastrophic Leave Will Begin: | Date the Catastrophic Leave Will End: |

If the above request is granted, I agree to the following:

1. I have donated the appropriate amount of sick leave to the Catastrophic Sick Leave Bank for this fiscal year.
2. I have exhausted all paid leaves according to the Catastrophic Sick Leave Bank guidelines and am unable to render service in excess of 30 days.
3. I will comply with the requirements and conditions set forth in the UACT contract.
4. I understand the maximum days available are fifty (50) days per catastrophic illness or injury. I understand I may request an additional twenty-five (25) days to be used concurrently with differential pay.
5. I understand that unused Catastrophic Sick Leave Bank days will be returned to the Bank.
6. I have read and understand the Catastrophic Sick Leave Bank guidelines.
7. I will inform Human Resources of any changes to my health status.

Employee Signature: _____ Date_____

## For Human Resources Use Only

**Is the employee enrolled in the Catastrophic Leave Bank:**

☐ Yes ☐ No

Catastrophic Leave Request Received: _____ Date _____ By

Catastrophic Leave Committee Met: _____ Date

☐ Catastrophic Leave Approved
☐ Catastrophic Leave Not Approved

_____ Signature: Assistant Superintendent, Human Resources

_____ Date