



**CSA Catastrophic Leave Request**

In addition to filling out this leave request, you must also attach a physician's statement which 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:	Extension to Original Request: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature:			Date:

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.
3. I will comply with the requirements and conditions set forth in the CSA contract.
4. If needed, I will request the allowable additional 20 days in writing and must attach the required doctor's note(s) for review and approval. I understand the maximum days available are eighty (80) days per catastrophic illness or injury.
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 Resource Services of any changes to my health status.

**For Human Resource Services Use Only**

Date Catastrophic Leave Request Received:

Received By:

\_\_\_\_\_

\_\_\_\_\_

Catastrophic Leave Approved

Catastrophic Leave Not Approved

Signature: Chief Human Resource Services Officer

Date

Please keep a copy for your own records.

cc: Human Resource Services, Personnel File  
Appropriate Supervisor  
Employee