PALOMAR COLLEGE
Learning for Success

# Classified Unit Employees
# Catastrophic Illness Leave Application

Date: _____ I, _____

request the award of_____hours from the Catastrophic Leave Bank.

*Check One:*

_____ I am seriously ill.
_____ A member of my immediate family _____(relationship) is seriously ill.

I have attached a physician's statement confirming that a serious illness exists. The statement also provides an estimate of the length of the illness.

I have exhausted all of my full-pay leave (sick leave, earned comp time, and vacation leave) and will not be receiving any other disability pay during the period for which I have requested leave hours from the Catastrophic Leave Bank (CLB). I understand that this leave will be coordinated with differential leave pay.

I understand that withdrawals from the CLB shall be terminated whenever:

1. I am able to return to work or the immediate family member for whom I am caring no longer needs home care to be provided by me.

2. I receive a monthly disability income from another source.

3. My employment with the District is terminated.

4. The CLB runs out of donated sick leave.

I understand that once I return to work, I must reapply if I wish to be considered for CLB leave as follows:

The certifying physician shall state the employee's degree of disability. If the disability is less than one hundred percent (100%), the physician shall state the hours per day that the employee is able to perform his/her essential duties.

I understand that the CLB Committee may determine that the employee is eligible to receive no more than a prorated daily portion of sick leave equivalent to the degree of disability.

_____ _____ _____
Signature of Employee or Agent Employee ID # Date

*SUBMIT TO: HUMAN RESOURCE SERVICES*

Revised 3/1/12