Full-Time Faculty
Catastrophic Illness Leave
Application

Date:____

I, ____

(Print name)

request the award of * ______________ days from the Catastrophic Leave Bank.

Check One:

_____ I am suffering from a catastrophic illness or injury.

_____ A member of my immediate family___________________(relationship) as defined in section 9.9.2 is suffering from a catastrophic illness or injury.

I have attached a physician's statement confirming that a catastrophic illness or injury exists and estimating the length of the illness.

I have exhausted all of my full pay sick leave and will not be receiving any other disability pay (LTD, Workers' Compensation) during the period I have requested leave hours from the Catastrophic Leave Bank.

________________________________ ______________________

Signature of Employee or Agent Date

*The maximum amount of Catastrophic Illness Leave is 90 days including substitute differential leave. Leaves are approved in allotments not to exceed 30 days at a time. A new request must be submitted for days in excess of 30.

SUBMIT TO: HUMAN RESOURCE SERVICES