Catastrophic Sick Leave Bank Request Form

Employee Name: ________________________________ TEAMS ID: ______________

Address: ______________________________________ Phone #: ________________

City,State, Zip: ________________________Campus/Department: ________________

I request consideration for approval of Catastrophic Sick Leave Bank (CSLB) days for the following medical reason.

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First date of absence due to this condition: ______________________________________

My accumulated leave days will be exhausted as of: ______________________________
(Accumulated leave balances do not include forwarded days issued on July 1st, which have not been earned)

( ) This is my initial request

( ) I have already received 30 days from the Catastrophic Sick Leave Bank. This is an additional request.

I am requesting CSLB days as of____________________________

Any leave days given to a contributor shall be coordinated with any collateral benefits being received by the contributor, so that the sum of the amount of collateral benefits and the amount of the sick leave benefits received does not exceed pre-illness or pre-injury rate of pay.

( ) I have the disability product. I understand the disability product is a collateral benefit and payment from the CSLB will be offset by my daily disability rate.

( ) I do not have the disability product.

This completed application must be accompanied by medical certification signed by a licensed physician.

Signature____Date__________________

FOR DISTRICT USE ONLY-Disability: ______________ __________ Worker's Compensation:__________

Accumulated leave exhausted on: ______________________________

Approved by:
____Date:____________________

Comments:
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