

# Request for the use of Catastrophic Leave – Certificated

(Return completed form to Human Resources offices)

Name \_\_\_\_\_ School \_\_\_\_\_ Date \_\_\_\_\_

**Eligibility** – Bargaining unit members may apply for and be eligible to receive catastrophic leave pursuant to the following:

1. The unit member is suffering from an incapacitating illness or injury that is expected to continue for an extended time, as verified by the attending physician preventing the unit member from performing their regularly assigned work.
2. The time off work must create a financial hardship for the unit member because they have exhausted all accrued sick leave and other paid time.

**Note:** Catastrophic leave will run concurrently with the extended disability leave in Article VII, Section 3, of the SDTA/District Agreement.

The following elements will be considered in determining eligibility for the use of leave bank and the number of days to be granted:

- ❖ Contribution to the bank is current
- ❖ Total number of days available in the bank
- ❖ Nature and duration of illness
- ❖ Availability of other alternatives for the applicant
- ❖ History of sick leave use

**\*\*Note** – There are limits to the number of days the Catastrophic Leave Committee is allowed to grant to an individual member

## Please Complete the Following:

1. **Attach** the attending physician’s statement, stating the expected length of the absence, on the physician’s letterhead and with the physician’s signature.
2. What will be the approximate duration of the disability?
4. Requested number of days? \_\_\_\_\_ 5. Date leave to begin \_\_\_\_\_
6. What was or will be the first date of absence related to this illness? \_\_\_\_\_
7. Do you have salary continuation (disability) insurance? \_\_\_\_\_  
 7a. If so, what benefits are provided? \_\_\_\_\_
8. The committee will consider your previous use of sick leave over the last few years. Are there any particular circumstances you want to make the committee aware of, including the use of personal necessity leave? (Attach additional page if relevant)
9. Additional information regarding the illness, special circumstances, etc. (Attach additional page if necessary)

**Signature of applicant** \_\_\_\_\_

*Please refer to the current contract for additional information*

### For Office Use Only:

Number of accrued sick leave days: \_\_\_\_\_ Eligible: Yes \_\_\_\_\_ No \_\_\_\_\_  
Number of days out in current year \_\_\_\_\_ Last day covered by sick leave \_\_\_\_\_

Request is: Granted \_\_\_\_\_ Denied \_\_\_\_\_

Reason for denial: \_\_\_\_\_

Number of days granted: \_\_\_\_\_ Beginning date: \_\_\_\_\_ Ending date: \_\_\_\_\_

Signature of each committee member:

\_\_\_\_\_  
\_\_\_\_\_

|   |
|---|
| Confirmation of receipt of request sent:<br>_____ |
|---|