



**Department of Finance and Administration - Office of Personnel Management  
Catastrophic Leave Bank Program Application for Maternity Purposes**

Authorized by ACA §§ 21-4-203, 21-4-209, 21-4-214

OPM Case # \_\_\_\_\_

**Instructions:** Please complete this form to apply for catastrophic leave for maternity purposes. Type or print legibly. Note: the requirements by each maternity purpose below. Provide the completed application and applicable requirement to your supervisor.

**NOTE:** The award of catastrophic leave for maternity purposes is based on the availability of donated leave within the OPM Catastrophic Leave Bank and the employee's eligibility for and compliance with law, policy and procedure.

**Part I - Application and Certification:** (To be completed by employee or designee on the employee's behalf.)

Employee's Name (Last, First) _____	Personnel Number _____
Agency Number and Name _____	Work Phone _____
Home Address _____	Home/Cell Phone _____
	Home e-mail address _____

**Applicant Certification:** (Check the appropriate box.)

**I certify I am requesting catastrophic leave for maternity purposes due to:**

- 1. The birth of my biological child. (Applicant must provide agency HR officer acceptable proof of actual date of birth.)
- 2. The placement of an adoptive child in my home. (Applicant must provide agency HR officer acceptable proof of placement date.)

**I understand and agree with the following:**

I have been employed with state government for at least one (1) year in a regular, full-time position.  
 I am not required to exhaust annual or sick leave before being granted catastrophic leave for the maternity purpose stated above.  
 I will not accrue annual or sick leave while receiving catastrophic leave for the maternity purpose stated above for the month the catastrophic leave begins.  
 If, during the period the employee is in a catastrophic leave status, any birthday or holiday leave is accrued, it will be removed and reflected as catastrophic leave.  
 I may be granted up to four (4) consecutive weeks of catastrophic leave with pay within the first twelve (12) weeks after the birth of my biological child or placement of an adoptive child in my home.  
 After the expiration of the four (4) weeks of catastrophic leave for either maternity purpose above, maternity leave shall be treated as any other leave for sickness or disability per ACA § 21-4-209.  
 I will forfeit the catastrophic leave benefits if I terminate my employment or my employment is terminated.  
 I will have my approved catastrophic leave for maternity purposes run concurrently with the Family and Medical Leave Act (FMLA) provisions, if eligible.  
 I will comply with the provisions of law, policy and procedure; if verified abuse, misrepresentation or fraud is found, I shall repay all of the leave hours awarded me from the OPM Catastrophic Leave Bank and be subject to disciplinary action up to and including termination.  
 I have not applied for and am not receiving social security disability benefits.  
 Any unused catastrophic leave for the maternity purpose stated above shall be returned to the OPM Catastrophic Leave Bank.  
 I consent to the encrypted electronic distribution of this document within and outside the agency for the purpose of completion, consideration and determination by my agency and DFA-OPM.

\_\_\_\_\_  
 Signature of Employee/Designee Requesting  
 Catastrophic Leave for Maternity Purposes

\_\_\_\_\_  
 If Designee, State Relationship

\_\_\_\_\_  
 Date

**Part II - Supervisory Verification:** (To be completed by employee's supervisor.)

I am aware this employee is  will be  eligible to apply for catastrophic leave for maternity purposes from the date of this application.

\_\_\_\_\_  
 Agency Supervisor's Name/Signature

\_\_\_\_\_  
 Position Title

\_\_\_\_\_  
 Work Phone

\_\_\_\_\_  
 Date

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Employee's Name (Last, First) \_\_\_\_\_ Personnel Number \_\_\_\_\_

**Part III - Human Resources Verification:** (To be completed by the agency human resources officer or designee regarding the employee.)

Position Title \_\_\_\_\_ Class Code \_\_\_\_\_ Pay Grade \_\_\_\_\_ Position # \_\_\_\_\_

Full-time  Yes  No Hourly Rate of Pay \_\_\_\_\_ Career Service Date \_\_\_\_\_

Latest Hire Date \_\_\_\_\_ Last Day Worked \_\_\_\_\_ Date of Birth \_\_\_\_\_

Beginning date of approved catastrophic leave for maternity purposes \_\_\_\_\_ Expected ending date \_\_\_\_\_

Total hours requested \_\_\_\_\_ Proof of birth or placement has been provided:  Yes  No

**Shared Leave Benefits:**  Yes  No Applicant applied for and was awarded shared leave for this event during the past one (1) year period.

If yes, how many hours of shared leave were used by the applicant: \_\_\_\_\_

**Catastrophic Leave for Illness/Injury Benefits:**  Yes  No Applicant applied for catastrophic leave for illness/injury during the past one (1) year period.

If yes, how many hours of catastrophic leave were awarded/used by the applicant? \_\_\_\_\_ / \_\_\_\_\_

**Catastrophic Leave for Maternity Purposes:**  Yes  No Applicant applied for catastrophic leave for maternity purposes during the past one (1) year period.

If yes, how many hours of catastrophic leave were awarded/used by the applicant? \_\_\_\_\_ / \_\_\_\_\_

**Workers' Compensation Benefits:**  Yes  No Applicant applied for/was receiving Workers' Compensation during the past one (1) year period.

If yes, what is the status of the application?  Applied  Pending  Approved  Denied

Date workers' comp began \_\_\_\_\_ Expected duration \_\_\_\_\_

Amount of workers' comp benefits \_\_\_\_\_ Hourly rate of pay on date of accident? \_\_\_\_\_

In conjunction with workers' comp benefits, how many hours of catastrophic leave for maternity purposes are needed weekly? \_\_\_\_\_

**FMLA:** Has the applicant applied for family and medical leave?  Yes  No Will the approved catastrophic leave run concurrently with FMLA leave?  Yes  No

If no, explain: \_\_\_\_\_

\_\_\_\_\_  
Agency Human Resources Officer's or Designee's Name/Signature Position Title Work Phone Date

**Part IV - Agency Director or Designee Verification:** (To be completed by the agency director or designee.)

I certify the employee's application for catastrophic leave due to the designated maternity purpose is appropriate and the information provided by the agency is complete and correct.

\_\_\_\_\_  
Signature of Agency Director/Designee

\_\_\_\_\_  
If Designee, State Title

\_\_\_\_\_  
Date

Employee's Name (Last, First) \_\_\_\_\_ Personnel Number \_\_\_\_\_ OPM Case # \_\_\_\_\_

**MATERNITY PURPOSES**

**Part V - DFA OPM Catastrophic Leave Bank Program Review and Determination:**(To be completed by DFA OPM Coordinator or designee.)

Date received \_\_\_\_\_ Date reviewed \_\_\_\_\_

Application Approved:  Yes  No  Pending

Beginning Date \_\_\_\_\_ Projected ending date \_\_\_\_\_

Total hours awarded \_\_\_\_\_ Total dollar Value of leave awarded: \$ \_\_\_\_\_

Reason for denial/pending: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
DFA OPM Coordinator's or Designee's Signature                      Work Phone                      Date

**Part VI- Record Keeping:** (To be completed by DFA OPM Coordinator or designee.)

Date recorded to file \_\_\_\_\_ Date sent to applicant/agency \_\_\_\_\_

Recorder's initials \_\_\_\_\_