Department of Finance and Administration - Office of Personnel Management

Catastrophic Leave Bank Program Application for Medical Emergency due to Illness/Injury Purposes

Print Form

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 a medical emergency due to illness/injury. Type or print legibly and attach all required documentation. Provide the completed application and applicable requirement to your supervisor.

NOTE: The award of catastrophic leave for medical emergency 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 _____

Name of Patient _____ Relationship to Employee _____ Patient's date of birth

Applicant Certification: (Check the appropriate response for each statement.) **I certify:**

Yes ☐ No ☐ 1. I am requesting catastrophic leave for a medical emergency due to illness/injury purposes as stated on the Physician's Certification.

Yes ☐ No ☐ 2. I will have exhausted all paid accrued leave before using approved catastrophic leave for the medical emergency.

Yes ☐ No ☐ 3. I expect to be absent from work without paid leave due to this medical emergency.

Yes ☐ No ☐ 4. I had at least 80 hours of combined sick and annual leave at the onset of this medical emergency or I have attached the required documentation to request an "extraordinary circumstance" waiver of the 80 hours.

Yes ☐ No ☐ 5. I am eligible for retirement or social security/social security disability benefits.

Yes ☐ No ☐ 6. I have applied for retirement benefits; date of application. _____

Yes ☐ No ☐ 7. I have applied for social security/social security disability benefits; date of application. _____

Yes ☐ No ☐ 8. I am receiving social security/social security disability benefits; date benefits began _____

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 will not accrue annual or sick leave while receiving catastrophic leave for the medical emergency during a period of 10 or more days in a month.

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.

Any unused catastrophic leave for the maternity purpose stated above shall be returned to the OPM Catastrophic Leave Bank.

I will forfeit the catastrophic leave benefits if I terminate my employment or my employment is terminated.

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 will have my approved catastrophic leave due to illness/injury run concurrently with the Family and Medical Leave Act (FMLA) provisions, if eligible.

The recommendations of the OPM Catastrophic Leave Bank Committee or the State Personnel Administrator are not subject to grievance, arbitration or litigation.

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 a Medical Emergency

If Designee, State Relationship

Date

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

From the date of this application, the employee has ☐ has not ☐ received a documented disciplinary action for leave abuse during the last one (1) year period.

_____ _____ _____

Agency Supervisor's Name/Signature | Position Title | Work Phone | Date

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

Date employee will begin Leave Without Pay (LWOP) Total catastrophic leave hours requested _____

Beginning Date of Approved Catastrophic Leave Expected ending date of Approved Catastrophic Leave

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 Worker's Comp began Expected Duration

Amount of workers' comp weekly 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 agency director or his/her designee)

I certify the employee's application for catastrophic leave due to a medical emergency is appropriate and the information and supporting documentation provided by the agency is complete and correct.

_____ _____ _____

Signature of Agency Director/Designee | If Designee, State Title | Date

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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 _____

_____ _____ _____

DFA OPM Coordinator's or Designee's Name/Signature Work Phone Date

Part V - DFA OPM State Personnel Administrator Review and Remarks (To be completed by State Personnel Administrator)

☐ I concur with the Committee's recommendation.

☐ I request Committee reconsider its recommendation.

_____ _____

DFA OPM State Personnel Administrator's Signature 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 _____