

**Arkansas State University-Newport**  
**Catastrophic Leave Bank Program**  
**(Authorized by Act 160 of 1991)**

Case Number:		<b>Note:</b> Catastrophic Leave is based upon Catastrophic Leave Pool time availability. This program does not create any expectation of continued employment. Applicants must have previously joined the Catastrophic Leave Bank and leave usage must be approved by the Catastrophic Leave Committee.	
<b>Instructions:</b> Please type or print legibly. Complete this form to apply for Catastrophic Leave. Attach to this form all appropriate documentation of the medical condition, including the physician's certificate stating a brief description of the nature and severity of the medical emergency, the medical prognosis and the anticipated duration of the leave needed. Submit the completed form to your supervisor for signature, then to the Department of Human Resources.			
<b>Part I - Application and Certification:</b> To be completed by employee or designee on his/her behalf.			
Employee Name:			
Department:	Supervisor:	Position:	
Date of Hire:	Sick Leave Balance:	Vacation Leave Balance:	
Last Date Worked:	Projected Return to Work:		
<b>Part II - Patient Information:</b>			
Patient Name:		Relationship to Employee:	
Nature of Illness / Injury:			
<p>The following have been applied for:</p> <p>Retirement Benefits -    <input type="checkbox"/> Yes   <input type="checkbox"/> No    If yes, date applied for: _____</p> <p>Long Term Disability -    <input type="checkbox"/> Yes   <input type="checkbox"/> No    If yes, date applied for: _____</p> <p>Social Security Disability - <input type="checkbox"/> Yes   <input type="checkbox"/> No    If yes, date applied for: _____</p>			
<b>Certification:</b> 1. I (or family member) have been affected by a medical emergency described on the attached Physician's Certification. 2. I have or will have exhausted all leave and compensatory time as of the date indicated. 3. I expect to be absent from work without paid leave because of this medical emergency.		4. I am a member of the Catastrophic Leave Bank. 5. I understand that any leave accrued while on Catastrophic Leave will be returned to the Catastrophic Leave Bank. 6. I certify that I am the only option for providing care for the individual identified (if family member).	
Signature of Employee Requesting Catastrophic Leave:		If employee is unable to sign, state relationship of designee making request:	Date:

<b>Part III - Supervisor Verification:</b> To be completed by employee's immediate supervisor.		
Has employee been disciplined for leave abuse during the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:		
Explain why this employee's leave has been exhausted (be specific):		
Is this injury/illness job related (workers' comp)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Could this job be restructured temporarily to allow employee to return to work at an earlier date? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain or attach modified job description:		
Signature of Supervisor:	Title:	Phone Number:
		Date:
<b>Part IV - Human Resources Verification:</b>		
Is employee member of the Catastrophic Leave Bank? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date all leave will be exhausted (includes sick, vacation and compensatory leave):	
<b>Part V - Catastrophic Leave Committee Review and Recommendation:</b>		
Date Received:	Date Reviewed:	Application Approved? <input type="checkbox"/> Yes <input type="checkbox"/> No
Duration of Approved Leave: Beginning _____ Ending _____		
Signature of CLB Committee Chair/ Designee:		Date:
<b>Part VI – Chancellor's Review and Action:</b>		
Final Action: <input type="checkbox"/> Approved <input type="checkbox"/> Denied		
Signature of Chancellor:		Date:
<b>Part VII - Payroll Processing:</b>		
Total Hours Approved:	Rate of Pay Per Hour:	Date CLB Ends:
Notes:		