LOS RIOS COMMUNITY COLLEGE DISTRICT
APPLICATION FOR CATASTROPHIC ILLNESS OR INJURY LEAVE
Classified and Management Employees

Instructions: Employee or representative is to complete this form and attach the Physician's Statement and the Authorization for Release of Medical Information form. All forms are to be returned to the Employee Benefits Department which will verify eligibility and forward to Human Resources for processing.

Employee Name _____ Job Title _____

Employee ID #_____ Work Phone_____ Home Phone_____

Location: ☐ ARC ☐ CRC ☐ FLC ☐ SCC ☐ DO/FM

Unit: ☐ LRCEA ☐ SEIU ☐ LRSA ☐ MGMT/CONF

I wish to apply for the Catastrophic Illness or Injury Leave Program. I understand that I may apply for up to ninety (90) calendar days of leave commencing the first day that I am in less than full pay status. I understand that I must exhaust all my eligible leave balances before being eligible for the Catastrophic Illness or Injury Leave Program and that I may be awarded Catastrophic Leave only once per illness or injury.

I am requesting Catastrophic Leave from ____/____/____ to ____/____/____ for:

☐ **Personal Illness or Injury** *Check here if this is an extension to an approved Cat Leave:* ☐
Describe the nature of the incapacitating illness/injury:

_____

_____

OR

☐ **Immediate Family Member Illness or Injury**

Name of Family Member:_____

Relationship: _____

Describe the nature of the incapacitating illness/injury:

_____

_____

Attach additional page if needed and a Physician's Statement verifying your or your immediate family member's incapacitation.

I hereby request approval for the Catastrophic Illness or Injury Leave Program. I have attached a Physician's Statement verifying my illness/injury or that of an immediate family member. If leave request is due to an immediate family member, I hereby verify that I am required to care for this family member for the requested period of time which extends beyond my available leaves. I have also attached the Catastrophic Illness or Injury Leave Medical Certification form.

Employee Signature _____ Date_____

HR Use Only ☐Approved for _____ days. ☐ Denied. Reason: _____

_____

_____ _____
Signature – HR Director Date

Distribution: White *and* Canary: Human Resources Pink: Employee BS #185 / 3/2014