LOS RIOS COMMUNITY COLLEGE DISTRICT

APPLICATION FOR EXTENDED PAID CATASTROPHIC SICK LEAVE

Los Rios Faculty

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 Associate Vice Chancellor, Human Resources.

Employee Name _____Job Title_____

Work Location ___ARC ___CRC ____ FLC ___ SCC ___ DO/FM

Employee ID #_____Work Phone_____ Home Phone_____

I wish to apply for the Extended Paid Catastrophic Sick Leave available per Article 9.13 of the LRCFT Contract. I understand that I may apply for up to eighty-two (82) workdays of leave commencing the first day that I am in less than full pay status and ending no more than 82 days later. I understand that I must exhaust all my eligible leave balances and not be eligible for disability, workers' compensation, or other benefits, to be eligible for the Extended Paid Catastrophic Sick Leave. If I wish to apply for an extension, I understand I must submit a new application with supporting documentation.

Leave for Personal Illness or Injury:

Describe the nature of the injury/illness & the expected length of time you will be incapacitated from work.

A Physician's Statement verifying your incapacitation must be attached to the application.

I hereby request approval for the Extended Paid Catastrophic Sick Leave. I have attached a physician's statement verifying my illness/injury. I have also attached the Authorization for Release of Medical Information form.

Employee Name (please print)_____

Employee Signature_____Date_____

Committee Use Only:

Leave: ☐ Approved for_____ days. ☐ Denied_____
Reason

Start Date_____ End Date_____

_____
Signature – Assoc. Vice Chancellor, HR Date

Distribution: White *and* Canary: Human Resources Pink: Employee BS# 200 4/2010