University of Arkansas at Monticello
Catastrophic Leave Bank Program
Application

Applicant Information:

Applicants Name:_____ I.D. Number: _____

Position: _____ Dept/Unit: _____

Patient Name:_____ Relationship: _____

Work Phone: _____ Home Phone:_____

Catastrophic Leave Requested:

Beginning Date: _____ Ending Date: _____
(Will be earlier if physicians return-to- work date is prior to the ending date of the hours requested.)

Total Hours Requested: _____

If you are requesting leave intermittently, please attach schedule.

Eligibility and Acknowledgements:

_____ I or the patient has been affected by a medical condition described on the attached Physician's Certification.

_____ I understand I must submit the committee an acceptable medical certificate from the physician supporting the absence stating the employee/patient is not able to perform his/her job due to the illness.

_____ I agree that any leave that I accrue while on Catastrophic Leave will be returned to the Catastrophic Leave Bank.

_____ I understand I must be a full-time employee who is in a regularly appointed position. A person who works less than full-time (forty hours per week) is not eligible.

_____ I understand I must be employed by a State of Arkansas agency including UAM) in a full-time regular position for two years although the two years need not be continuous.

_____ I understand that the catastrophic illness has prevented me from performing my duties for a prolonged period of time (30 working days, 240 hours) prior to the Catastrophic Leave beginning date.

_____ I understand I must have not been disciplined for any leave abuse during the last two years of employment.

Dated November 8, 2007

_____ If the illness or injury is that of an employee and is covered by workers compensation and catastrophic leave at the same time payment cannot exceed the amount of the employee's UAM regular appointed salary.

_____ I understand that if I return to employment prior to the timeframe noted on the physician certificate, I must submit a medical provider statement allowing such return to work if I am the patient.

_____ I understand I will not receive catastrophic leave beyond the date the physician certifies that the employee is able to return to work regardless of the approval ending date.

_____ I understand I shall not be approved for catastrophic leave unless the employee is or is expected to be in a leave-without-pay status. I have, or will have, exhausted all accrued leave and compensatory time as of the beginning date indicated.

_____ I understand that I must furnish my supervisor periodic reports of any status changes during my Catastrophic Leave time frame and my intent to return to work.

Supervisory Section:

Date last employee was present for work: _____

Do you support and recommend this employee receiving the requested leave? ☐ Yes ☐ No
If no, attach explanation or reason.

Do you approve this employee being allowed to working intermittently ☐ Yes ☐ No
as indicated above?
If no, attach explanation or reason.

Signature of Supervisor: _____ Date: _____

Position Title: _____ Phone Number: _____

Time Keeper:

Date or estimated date employee will exhaust accrued leave: _____

Verified by UAM Personnel Office:

Signature: _____ Date: _____

Dated November 8, 2007

Catastrophic Leave Committee Review and Recommendation:

Date Received:_____ Date Reviewed:_____

Application Recommended: ☐Yes ☐No Total Hours Recommended:_____

Beginning Date:_____ Projected Ending Date:_____

Notes:_____

_____

_____

_____ _____

CL Committee Chairperson/Designee Signature Date

Chancellor's Review and Action:

☐ _____ Approved ☐ _____Denied

_____ _____

Chancellor's Signature Date

Dated November 8, 2007