DIVISION OF AGRICULTURE
RESEARCH & EXTENSION
University of Arkansas System

U of A System Division of Agriculture Catastrophic Leave Bank Program
Application for Medical Emergency Due to Illness/Injury

Please Type or Print Legibly

Instructions: Complete this form to apply for Catastrophic Leave. Attach all appropriate documentation of the medical emergency. Present form to the Human Resources Office. Refer to the Catastrophic Leave Bank Program Policy for additional information.	**Note:** The award of Catastrophic Leave is dependent upon its availability within the Catastrophic Leave Bank. The program does not create any expectation or promise of continued employment.

Part I - Application and Certification (*To be completed by applicant or designee on his/her behalf*).

Patient Name (Last, First, Middle Initial) * *if different than the employee*	Relationship to Employee

Employee Name (Last, First, Middle Initial)	Work Location

Work Phone Number	Work Fax Number	Home Phone Number	Birthday: Day/Mo./Yr.

Amount of Catastrophic Leave Requested		Duration Dates of Catastrophic Leave Request	
Last Day Worked	Total Time Requested	Beginning Date	Projected Date

Certification: (Check all appropriate sections) ***I certify that***:

1. ☐ I have been affected by a medical emergency described on the attached Physician's Certification.
2. ☐ I expect to be absent from work without paid leave because of this medical emergency.
3. ☐ I have applied for and am receiving Worker's Compensation Benefits in connection with this work-related condition.
4. ☐ I have applied for but am not receiving Worker's Compensation Benefits in connection with this work-related condition.
5. ☐ I expect to be absent from duty for at least twenty (20) continuous working days because of the medical emergency.

I understand and agree with the following:

- I have been employed with the University of Arkansas System for at least one (1) year in a regular, full-time (100%) position.
- While on catastrophic leave for medical emergency, all my accrued sick and annual leave will be returned to the Catastrophic Bank.
- I will forfeit the catastrophic leave benefits if I terminate my employment or my employment is terminated; or if there is any fraud or misrepresentation of facts in making application for leave from the Catastrophic Bank.
- I will have my approved catastrophic leave due to illness/injury run concurrently with the Family Medical Leave Act (FMLA) provisions, if eligible.
- The decisions of the Catastrophic Leave Committee or the Director of Human Resources are not subject to any grievance, arbitration, or litigation.

Signature of Employee Requesting Catastrophic Leave or Designee	If Designee, state your relationship to Requestor	Date

Part II – Human Resources Verification

Full Time (100%) UASYS Employee for Minimum of 1 Year ☐ Yes ☐ No Employee ID:	Written Disciplinary Action for Leave Abuse during the past 1 year period from date of application? ☐Yes ☐ No	Employee had at least 80 hours of combined sick and annual leave at the onset of this illness/injury. ☐Yes ☐ No

Physician Statement indicates illness requires at least twenty (20) continuous working days absence from duty because of medical emergency.
☐ Yes ☐ No

Human Resource Official (Print)	Human Resource Official Signature	Phone Number	Date

Part III - Catastrophic Leave Committee Recommendation & HR Director Approval

Date Reviewed by Committee	Committee Recommendation ☐ Yes ☐ No	Recommended Length of Catastrophic Leave	
		Beginning Date: (Per Physician)	Ending Date: (Per Physician)
Signature of Catastrophic Leave Bank Committee Chair/Designee		***Date Signed:	
Date Reviewed by HR Director	Committee Recommendation Approved ☐ Yes ☐ No	Signature of HR Director	
** Document submitted to Financial Services Payroll Representative by:		Date Submitted	

** Completed by HR/Begin Date excludes leave exhaustion
***Date may be different from date reviewed if Committee Chair signs at a later date.

Part IV - Payroll Verification

Current Balance (Dollar Value) in Catastrophic Leave Bank:	Latest Hire Date	Company Service Date	Estimated Date Leave Exhausted (includes Annual, Sick, Holiday and Comp)	Duration Dates of Catastrophic Initial Block of Time Leave Request 20 continuous working days		Estimated Total Dollar Value and Number of Catastrophic Hours to be Used
				Beginning Date (Per Physician):	End Date (Per Physician):	

Signature of Payroll Officer	Position Title	Phone Number

Worker's Compensation Status

Applied? Date	Approved? Date	Pending? Date	Denied? Date
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Amount of Worker's Compensation Weekly Benefits	Hourly Rate on Date of Accident	Hours of Catastrophic Leave Requested Weekly
Date Worker's Compensation Commenced	Expected Duration	Date
Signature of Payroll Officer	Position Title	Phone Number