ARKANSAS TECH UNIVERSITY

Catastrophic Leave Bank Program
Recipient Application Form

Please Type or Print Legibly

Authorized by A.C.A. 21-4-214 et.seq.

Case # _____

Instructions:	**Complete this form to apply for catastrophic leave time. Attach to this form all appropriate documentation of medical emergency such as the Physician's Certification for Catastrophic Leave and the Catastrophic Leave Bank Release from Liability. After completion of these procedures, present this form to your supervisor.**
Note:	**Catastrophic leave time is based upon availability within the University's Catastrophic Leave Bank. The program does not create any expectation of promise of continued employment.**

Part I – Application & Certification (To be completed by the applicant employee or designee on his/her behalf)

Name (Last, First, Middle Initial)		Position Number	Employee ID Number	Class Code of Position
Date of Birth	**Grade**	**Name and Address of Assigned Duty Station**		

Position Title	**Work Phone Number:** **Home Phone Number:**
Amount of Catastrophic Leave Requested **(Total Hours Requested in One (1) Hour Increments)**	**Duration Dates of Catastrophic Leave Request** **Beginning Date** — **Projected Ending Date**

Certification: **(if certifying on behalf of an employee, modify as appropriate)**

I certify that:

(1) I have been affected by a medical emergency, described on the attached Physician's Certificate.
(2) I have or will have exhausted all annual, sick, holiday leave and compensatory time as of date indicated above.
(3) I expect to be absent from duty without paid leave because of this medical emergency.
(4) I agree that any leave accrued while on catastrophic leave will be returned to the Catastrophic Leave Bank.

Signature of Recipient or His/Her Designee (please specify)	If Designee, State Your Relationship to Recipient	Date
Recipient:		
Designee:		

Part II – Supervisory Verification

To Be Completed by Employee's Supervisor

Has the employee suffered a great loss of sick and/or annual leave due to a personal illness prior to this request? Yes____No____	**Disciplinary Action for leave abuse during past two years? Yes___ No___**
Signature of Supervisor:	**Date:**

Part III – Personnel/Payroll Verification (To be completed by Department of Human Resources)

Full Time	Hire Date	Adjusted Hire Date	Workers' Compensation Status			
			Applied?	Approved?	Pending?	Denied?
Yes__ No___			Yes___No____	Yes___No____	Yes___No____	Yes___No____

Signature of Authorized Human Resources Representative	Position Title	Phone #	Date

ARKANSAS TECH UNIVERSITY

Catastrophic Leave Bank Program
Recipient Application Form

Part IV – Payroll Verification			
Date Leave Exhausted (includes annual, sick, holiday and comp) **Date** **Time** **am** **pm**	**Beginning date of Cat Leave:** **Projected ending date of Cat Leave:**		
Total Hours Requested:	**Hourly Rate of Pay**	**Total Dollar Value Requested: $**	
Signature of Authorized Payroll Representative	**Position Title**	**Phone #**	**Date**

Part V – Catastrophic Leave Committee	
Date Reviewed:	**Recommendation of approval/denial to VP & President:** ☐ **Approve** ☐ **Deny**
Signature of CLB Committee Chairperson/Designee	**Date**

Part VI – Vice President Review	
Date Reviewed:	**Recommendation of approval/denial to President:** ☐ **Approve** ☐ **Deny**
Signature of Vice President	**Date**

Part VII – President Review and Action	
Date Reviewed:	☐ **Approve** ☐ **Deny**
Signature of President	**Date**

Arkansas Tech University
Catastrophic Leave Bank Program (CLB)
Physician's Certification

Note: *The employee and/or patient is responsible for the completion of this form at his or her own expense. All information listed on this form will be kept confidential and is not to be released to or by the employer without written consent of the employee.*

Name of Employee (Last, First) _____

Address (Street, City, State, Zip) _____

Name of Patient (Last, First) _____

Authorization to Release Information: I hereby authorize the undersigned physician to release information acquired in the course of my examination or treatment to my employer. My employer will provide his certification to the OPM Catastrophic Leave Bank Program for eligibility determination purposed for short-term disability benefits. I understand that this authorization to disclose information will expire thirty (30) days after the date of my signature or upon receipt by the physician of my written revocation, whichever comes first.

_____ _____

Employee's Signature (or Legal Representative) **Date**

_____ _____

Patient's Signature or Legal Representative (if Different than Employee) **Date**

****

To Be Completed by Patient's Physician

The following questions apply only to this injury/illness.

1. History

(a) When did the patient first seek treatment for this illness/injury? _____ Date

(b) Could this illness/injury be work related? ☐ Yes ☐ No

(c) To your knowledge, has the patient ever had the same or similar condition?
Yes ☐ No ☐

If "Yes," state when and describe: _____

_____

2. Present Condition

(a) Is surgery: ☐ Required? ☐ Elective?

(b) Date of Surgery: _____

(c) Is patient *(check one)* ? ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized

3. Diagnosis **Give a narrative of the nature and extent of the present illness/injury as well as diagnosis which is creating the need for short-term disability provided by the State's Catastrophic Leave Bank Program.**

_____

_____

_____

_____

4. Continuing Required Treatment for this Illness/Injury

(a) Projected Date of first office visit/treatment: _____
Date

(b) Frequency of visits/treatments ☐ Weekly ☐ Monthly Other _____

(c) When did you last examine patient? _____
Date

(d) Give a brief description of the continuing treatments required by this illness/injury:

_____

_____

_____

5. Prognosis and anticipated time duration that employee will be unable to work due to the health condition of employee or required direct care of a family member:

(a) If there are no further complications, what is the minimum recovery time of the patient before the employee may return to work?

Approximate Return Date: _____

(b) What is the maximum recovery time of the patient before the employee may return to work?

Approximate Return Date: _____

(c) If the patient is an employee of Arkansas Tech, is there a possibility of working intermittent or reduced schedule or returning to work on a part-time basis with job duties altered, within reason, to better fit his/her needs?

☐ Yes ☐ No If yes, Approximate Return Date: _____

Please explain any limitations:

_____

_____

Please feel free to attach any additional documentation.

Clinic Name	Address	Telephone
Physician's Name (print)	Physician's Signature	Date