Catastrophic Leave Sharing Program  
Request Form (*confidential*)

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| Please read the Catastrophic Leave Sharing Program Policy and Procedures completely to determine whether you are eligible to participate in the Catastrophic Leave Sharing Program. Once you have completed this form, please sign and submit to your department head or designee for signature.  Forward the completed form to the Human Resources Department at [catleave@ucr.edu](mailto:catleave@ucr.edu). | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Employee Name: | | |  | | | | | | | | | | | | Employee ID: | | | |  | | | | | |
| Job Title: | | |  | | | | | | | | | | | | Department: | | | |  | | | | | |
| Shared Services Center: | | |  | | | | | | | | | | | | Work Phone: | | | |  | | | | | |
| Length of UCR Service: | | | | | | Years: | | |  | | | | | | Months | | | |  | | | | | |
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| 1. Have you exhausted all sick leave, vacation leave and compensatory time off? | | | | | | | | | | | | | | | | | | Yes | | | No | | Pending | |
| 1. If yes, or pending, provide the effective date: | | | | | | | | | | |  | | | | | | | | | | | | | |
| 1. Have you completed the probationary period? | | | | | | | | | | | Yes | | No | | | | | | | | | | | |
| 1. How many hours are you requesting? | | | | | | |  | | | | | | | |  | | | | | | | | | |
| Block leave, maximum is 184 hours | | | | | | | | | | | | Intermittent leave, maximum is 80 hours | | | | | | | | | | | | |
| 1. What is the expected duration of your leave? | | | | | | | | From: | | | |  | | | | To: | | | |  | | | | |
| 1. Have you requested Catastrophic Leave Donations during the 12 months immediately preceding this request? | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Yes | No | | If yes, what was the amount of leave granted to you? | | | | | | | | | | | | |  | | | | | | | |
| 1. The catastrophic leave I am requesting is for: | | | | | | | | | | | | | | | | | | | | | | | | |
|  | My own serious health condition | | | | | | | | | My family member’s serious health condition | | | | | | | | | | | | | | |
|  | Pregnancy disability | | | | Death of a family member | | | | | | | | | | Catastrophic casualty | | | | | | | | | |
| 1. If the catastrophic leave request is for your own serious health condition, have you applied for disability benefits? | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Yes | No | | Not applicable | | | | | | | | | | | | | | | | | | | | |
| 1. Have you provided your supervisor with a medical certification form related to this serious health condition? | | | | | | | | | | | | | | | | | | | | | | Yes | | No |
| 1. Is the catastrophic leave request related to a work injury? | | | | | | | | | | | | | | Yes | | No | | | | | | | | |
| 1. Do you authorize the use of your name in requesting donations of vacation hours from fellow UCR employees? | | | | | | | | | | | | | | | | | | | | | | Yes | | No |
| 1. Have you received any formal disciplinary action for excessive absenteeism during the 12 months immediately preceding the request for catastrophic leave? | | | | | | | | | | | | | | | | | | | | | | Yes | | No |

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| --- | --- | --- |
| Signatures | | |
| *I understand my participation in the Catastrophic Leave Sharing Program is subject to the provisions outlined in the guidelines.* | | |
|  |  |  |
| **Employee Signature** |  | Date |

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| --- | --- | --- | --- | --- |
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| **Division/Department Head’s  (or designee’s) Signature** |  | Print Name |  | Date |

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| FOR SHARED SERVICES (OR DESIGNEE) USE ONLY | | | | | | | | | | | | | | |
| 1. Has all vacation, sick leave and compensatory time (if applicable) been exhausted? | | | | | | | | | Yes | | | No | | Pending |
|  | If pending, provide explanation: | |  | | | | | | | | | | | |
| 1. Have you verified if the employee is on an “approved leave of absence” for the dates requested for the catastrophic leave? | | | | | | | | | | | | Yes | | No |
| * 1. Type of “approved leave of absence”: (FML, Intermittent Leave, etc.) | | | | | |  | | | | | | | | |
| 1. Provide the anticipated amount (hours) of catastrophic leave needed: | | | | | | | |  | | | | | | |
| * 1. Include an itemized account of the hours needed with the corresponding calendar date: | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | |
|  | *(You can attach an itemized account of hours to the Catastrophic Leave Sharing Program Request Form)* | | | | | | | | | | | | | |
| 1. Comments: | |  | | | | | | | | | | | | |
|  | | | |  |  | | | | |  |  | | | |
| **Shared Services Administrator’s Signature** | | | |  | Print Name | | | | |  | Date | | | |
|  | | | | | | | | | | | | | | |
| FOR HUMAN RESOURCES USE ONLY | | | | | **This request is**: | | Approved | | | | | | Denied | |
|  | | | |  |  | | | | |  |  | | | |
| **HR Authorizing Signature** | | | |  | Print Name | | | | |  | Date | | | |
| Comments: | |  | | | | | | | | | | | | |