DEPARTMENT OF FINANCE AND ADMINISTRATION

Office of Personnel Management

Catastrophic Leave Bank Program Application for Benefits

Authorized by A.C.A §§ 21-4-203, 21-4-214, 6-63-601 & 6-63-602 Case # _____

Instructions

Complete this form to apply for Catastrophic Leave. Please type or print legibly. Attach all appropriate documentation of the medical emergency. Include the Physician's Certification for Catastrophic Leave and the Catastrophic Leave Bank (CLB) Liability Agreement. Present forms to your supervisor.

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 1 - Application and Certification: *(To be completed by employee or designee on their behalf)*

Employee's Name (Last, First, Middle Initial) _____ Personnel Number _____

Agency/Institution _____ Work Phone Number _____

Date of Birth _____ Home Phone Number _____ Position Title _____

Position Number _____ Position Class Code _____ Pay Grade _____ Hourly Rate of Pay _____

Name of Patient _____ Relationship to Employee _____

If employee has other qualifying family member(s) employed by the State, list their names below:

Name of Family Member	**Agency of Family Member**

Retirement and Social Security/Social Security Disability Benefits

☐ Yes ☐ No I am eligible for Retirement or Social Security benefits.

☐ Yes ☐ No I have applied for Retirement. If yes, date applied: _____

☐ Yes ☐ No I have applied for Social Security/Social Security Disability. If yes, date applied: _____

Shared Leave Benefits

☐ Yes ☐ No I have applied for Shared Leave for this event.

☐ Yes ☐ No I was awarded Shared Leave for this event during this calendar year.

I was awarded _____ hours.

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

☐ 1. I have been affected by a medical emergency described on the attached Physicians Certification.

☐ 2. I have, or will have, exhausted all leave and compensatory time as of the date indicated on page 2.

☐ 3. I expect to be absent from work without paid leave because of this medical emergency.

☐ 4. I had at least 80 hours of combined sick and annual leave at the onset of this illness/injury, or have attached the required documentation to receive an "extraordinary circumstance" waiver.

☐ 5. I have made application and am receiving Workers' Compensation Benefits in connection with this work-related condition.

☐ 6. I have made application but but am not receiving Workers' Compensation Benefits in connection with this work-related condition.

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

_____ _____ _____

Signature of Employee Requesting Catastrophic Leave or His/Her Designee | If Designee, State Relationship | Date

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Employee's Name (Last, First, Middle Initial) _____ Personnel Number _____

Part II - Supervisory Verification *(To be completed by Applicant's Supervisor.)*

Disciplinary Action for Leave Abuse During Past 2 Years? ☐ Yes ☐ No

Explain why this employee's leave has been exhausted. **Be Specific:**

Could this job be restructured temporarily to allow employee to return to work at an earlier date? ☐ Yes ☐ No If Yes, attach revised job duties.

Signature of Supervisor | Position Title | Phone Number | Date

Part III - Personnel/Payroll Verification *(To be completed by Agency/Institution Personnel/Payroll Officer)*

Full-Time ☐ Yes ☐ No Career Service Date _____ Latest Hire Date _____ Date Employee Would Go on LWOP _____

Last Day Worked _____ Total Hours Requested _____ Beginning Date _____ Projected Ending Date _____

Extraordinary Circumstances 80 Hour Waiver ☐ Yes ☐ No

Timekeepers Name | Timekeepers Signature | Phone Number | Date

Worker's Compensation Status

Applied ☐ Yes ☐ No Date _____

Approved ☐ Yes ☐ No Date _____

Denied ☐ Yes ☐ No Date _____

Pending ☐ Yes ☐ No

Hourly Rate on Date of Accident _____ Expected Duration _____

Amount of Worker's Compensation Weekly Benefits _____

Date Workers Compensation Commenced _____

Hours of Catastrophic Leave Requested Weekly _____

DISABILITY INSURANCE ***(FOR INSTITUTION EMPLOYEES ONLY)***

Does institution provide Employee Disability Insurance? ☐ Yes ☐ No

Has Employee filed for coverage? ☐ Yes ☐ No

Signature of Agency/Institution Personnel/Payroll Approving Authority | Position Title | Date

Part IV - Catastrophic Leave Committee Review and Recommendation

Date Received _____ Date Reviewed _____

Application Approved ☐ Yes ☐ No Beginning Date _____ Projected Ending Date _____

Total Hours Awarded _____ Total Dollar Value of Leave Granted _____

Signature of CLB Committee Chairperson/Designee | Date

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Employee's Name (Last, First, Middle Initial) _____ Personnel Number _____

Part V - Director's Review and Action

FINAL ACTION ☐ Approved ☐ Denied ☐ Concurred

_____ _____
Signature of Agency Director Date

Return original documents to:
University of AR at Pine Bluff
Human Resources, Mail Slot 4942, Pine Bluff,AR 71601

Part VI - CLB Record Keeper

_____ _____
Signature of CLB Record Keeper Date