UA LITTLE ROCK | DEPARTMENT OF HUMAN RESOURCES

University of Arkansas at Little Rock

Catastrophic Leave Bank Program

Recipient Application

Case Number:_____

***INSTRUCTIONS**: To apply for Catastrophic Leave, complete Part I and obtain supervisor's signature. The Physician's Certification should be returned to the Department of Human Resources only. The Liability Agreement and Dependent Child Certification should be submitted to the Department of Human Resources with the Recipient Application.*

***NOTE**: Catastrophic leave time is based upon availability within the University's Catastrophic Leave Bank. The program does not intent to 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)		T Number
Department	Work Phone Number	Home Phone Number
Requested Leave Beginning Date	Expected Leave Ending Date	Intermittent/Reduced Schedule Leave ☐ Yes ☐ No

Certification: (if certifying on behalf on an employee, modify as appropriate.) I Certify that:

1. I have been affected by a medical emergency as described on the Physician's Certification.
2. I have or will have exhausted all annual, sick, holiday and compensatory leave time.
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.
5. I expect to be absent from duty for at least 30 (thirty) working days or 6 (six) weeks because of the medical emergency.
6. ☐ I have applied for and am receiving Workers' Compensation benefits in connection with this work-related condition.

   ☐ I have applied but am not receiving Workers' Compensation benefits in connection with this work-related condition.

Signature of Employee or Designee	If designee, state your relationship to employee	Date
Signature of Department Head/Supervisor	Title	Date

PART II – Human Resources Verification		
Hire Date:	Adjusted Hire Date:	Disciplinary Action for Leave Abuse during Past 2 Years? ☐ Yes ☐ No *(If yes, attach documentation)*

Have you applied for Long Term Disability through UALR benefits plan? ☐ Yes ☐ No

Workers' Compensation Status

☐ Applied (Date:_____) ☐ Approved (Date:_____)	☐ Denied (Date:_____) ☐ Pending
Amount of Workers' Compensation Weekly Benefits	Date Workers' Compensation Commenced

Signature of HR Representative	Title	Date Sent to Payroll	Date Sent to CLBP

PART III – Payroll Verification			
Hourly Rate	Beginning Date of Loss of Income	Dollar Value of Leave/Hours	Balance of Leave in CLBP

Signature of Payroll Representative	Title

PART IV – Catastrophic Leave Committee Review and Recommendation		
Date Received	Date Reviewed	Application Approved? ☐ Yes ☐ No *If denied, state reason:*
Beginning Date		Projected Ending Date
Signature of CLB Chairperson/Designee		Date

PART V – Chancellor's Review and Action	
Application Approved? ☐ Yes ☐ No *If denied, state reason:*	
Signature of Chancellor	Date

COMPLETE FOR APPEAL ONLY		
PART VI – Chancellor's Appeal Review and Action		
Date Appeal Received	Date Appeal Reviewed	FINAL ACTION: ☐ Approved ☐ Denied
Signature of Chancellor		Date

Distribution: Original – Department of Human Resources
Copy – CLBP Chairperson