Arkansas State University
Catastrophic Leave Bank Program
APPLICATION FOR BENEFITS

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

Instructions: Please type or print legibly. Complete this form to apply for Catastrophic Leave. Attach to this form all appropriate documentation of the medical condition, including the physician's certificate stating a brief description of the nature and severity of the medical emergency, the medical prognosis and the anticipated duration of the leave needed. Submit the completed form to your supervisor for signature, then to the Department of Human Resources.	**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 his/her behalf)

Employee Name:		ASU Emp ID#:
Department:	Supervisor:	Position:
Date of Hire:	Sick Leave Balance:	Vacation Leave Balance:
Last Date Worked:	Projected Return to Work:	

___ Yes ___ No I am eligible for Retirement benefits. If yes, date applied for: _____
___ Yes ___ No I have applied for Retirement. If yes, date applied for: _____
___ Yes ___ No I have applied for Social Security Disability. If yes, date applied for: _____

Applicant Certification: (Check all appropriate sections)

I certify that:

___ I (or my family member) has been affected by a medical emergency described on the attached Physician's Certification. *(Requirement)*
___ I have, or will have, exhausted all Leave and Compensatory Time as of the date indicated. *(Requirement)*
___ I expect to be absent from work without paid leave because of the certified medical emergency in excess of 30 days. *(Requirement)*
___ I had at least 80 hours of combined sick and/or annual leave at the onset of the illness/injury. *(Requirement)*
___ If applicable, I have made application and am receiving Workers' Compensation Benefits in connection with this work-related condition.
___ If applicable, I have made application but am not receiving Workers' Compensation Benefits in connection with this work-related condition.

I understand any leave that I accrue while on Catastrophic Leave will be returned to the Catastrophic Leave Bank and that I meet all the requirements above to be eligible to request Catastrophic Leave. I also understand that the program does not create any expectation or promise of continued employment.

Signature of Employee Requesting Catastrophic Leave or His/Her Designee	Date

If Designee, state your relationship to Recipient:

Part II – Supervisory Verification (To be completed by Applicant's Supervisor) NOTE: Supervisor Signature Required on Next Page

Has employee been disciplined for leave abuse during the past two years? ___ Yes ____ No
If yes, please explain:

_____

_____

_____

Explain why this employee's leave has been exhausted (be specific):

_____

_____

_____

Is this injury/illness job related (Workers' Comp)? ____ Yes ____ No
If yes, explain:

Could this job be restructured temporarily to allow employee to return to work at an earlier date? ___ Yes ____ No
If yes, please explain or attach modified job description:

Signature of Supervisor:	Title:

Part III – Human Resources Verification: (To be completed by HR)

Full-Time Employee: ____ Yes ____ No	Career Service Date:	Latest Hire Date:
Date all leave will be exhausted (includes sick, vacation and compensatory leave):	Amount of Catastrophic Leave Requested:	
Duration Dates of Catastrophic Leave Request:	Date Employee Would Go on LWOP:	

WORKERS' COMPENSATION STATUS

Applied ___ Yes ___ No Date:	Approved ___ Yes ___ No Date:	Pending ___ Yes ___ No Date:	Denied ___Yes ___ No Date:
Amount of Workers' Compensation Weekly Benefits:		Hourly Rate on Accident Date:	
Date Workers' Compensation Commenced:		Expected Duration:	

DISABILITY INSURANCE

Has the employee filed for disability coverage? ☐ Yes ☐ No	Date insurance begins:	Number of months required for eligibility:
Signature of Authorized Agency/Institution Representative	Position Title	Phone Number

Part IV – Catastrophic Leave Committee Review and Recommendation

Date Received:	Date Reviewed:	Dates of Duration of Approved Catastrophic Leave	
		Beginning Date	Projected Ending Date:
APPLICATION APPROVED: ☐ YES ☐ NO	Total Hours Awarded:	Total Dollar Value of Leave Received:	
Signature of CLB Committee Chair/Designee:			Date:

Part V – Chancellor's Review and Action:

FINAL ACTION: ☐ APPROVED ☐ DENIED ☐ CONCURRED

Signature of Chancellor:	Date:

Part VI – Payroll Processing:

Total Hours Approved:	Rate of Pay Per Hour:	Date CLB Ends:

Additional Notes:

Arkansas State University
Catastrophic Leave Bank Program
PHYSICIAN'S CERTIFICATION

Employee Name _____

Last First Middle

Address _____

Street City/State Zip

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's Catastrophic Leave Bank Program Committee for eligibility determination purposes for short-term disability benefits. I understand that the 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.

_____ _____

Date Employee's Signature
(or Legal Representative)

_____ _____

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

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 BY THE EMPLOYER WITHOUT WRITTEN CONSENT OF THE EMPLOYEE.

(To be completed by the Patient's Physician)
Please Print or Type

THE FOLLOWING QUESTIONS APPLY ONLY TO THE CONDITIONS RELATED TO THE PATIENT'S APPLICATION FOR SHORT-TERM DISABILITY BENEFITS FROM THE ARKANSAS STATE UNIVERSITY CATASTROPHIC LEAVE BANK PROGRAM.

1. HISTORY

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

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

(c) To your knowledge has patient ever had the same or similar condition? Yes ☐ ☐
If "Yes", state when and describe:

_____

_____

_____

_____

_____

_____

2. PRESENT CONDITION

(a) Is surgery: Required ☐ Elective ☐ Date of Surgery: _____

When was the patient informed by the attending physician? Mo. _____ Day _____ Year _____

(b) Is patient? (Check one) Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized ☐

3. DIAGNOSIS: Give a brief narrative of the nature and extent of the present illness/injury which is creating the need for short-term Disability provided by the Arkansas State University Catastrophic Leave Bank Program:

_____

_____

_____

_____

_____

4. CONTINUING REQUIRED TREATMENT FOR THIS ILLNESS/INJURY

(a) Projected Date of the first office visit/treatment Mo. _____ Day _____ Year_____

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

(c) When did you last examine the patient? Mo. _____ Day _____ Year_____

(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 THE 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) Is there a possibility of the employee working an 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 limitations:

_____

_____

_____

_____

_____

Clinic Name Signature of Attending Physician

Address City, State Zip

Telephone Date