



Application for Catastrophic Leave Bank Credits

Name: _____ Social Security Number or Banner ID: _____

Mailing Address: _____ Home Phone: _____

To the faculty member: ALL of the following must be completed when a Catastrophic Leave Bank member is applying for leave credits:

☐ I understand that I am responsible for being knowledgeable of all of the provisions governing the Catastrophic Leave Bank, as written in Appendix D of the CCFT/District contract.

☐ In cases of my own catastrophic injury or illness,* I have attached a written statement and verification of my catastrophic illness or injury from a licensed physician or practitioner indicating 1) the nature and extent of the illness or injury, 2) that I am medically unable to work due to the illness or injury, and 3) the probable length of absence from work.

☐ In cases of time off to care for a member of my immediate family with a catastrophic injury or illness,* I have attached a written statement and verification of my family member's catastrophic illness or injury from a licensed physician or practitioner indicating 1) the nature and extent of the illness or injury, 2) that I am unable to work because I am required to care for my family member due to the illness or injury, and 3) the probable length of absence from work.

Choose one of the two below:

☐ I have verified that my illness or injury does not qualify me for State workers' compensation benefits.

or ☐ I have verified that my illness or injury qualifies me for State workers' compensation benefits and that I have exhausted all applicable district industrial accident and illness leave benefits.

☐ I have attached a signed statement explaining the circumstances that require my absence from work for an extended period of time (due to my or a family member's catastrophic illness or injury).

☐ I have attached written verification from the Cuesta College Human Resources Office that I will have used all of the appropriate combination of my available accrued sick, vacation, compensatory, personal necessity, industrial accident or injury, and other paid leave or leave without pay (as determined by Appendix D, Section D of the CCFT/District contract) by the date of the beginning of leave credits requested.

☐ Dollar amount that I am requesting or number of leave credit hours that I am requesting (e.g., "to cover my paycheck to the end of the XX semester"): _____

Signature _____

Today's Date _____

* CCFT and Cuesta College are required to use the Education Code 87045(a)1 definition of "catastrophic illness" or "injury." The Education Code currently defines these as "an illness or injury that is expected to incapacitate the employee for an extended period of time, or that incapacitates a member of the employee's family which incapacity requires the employee to take time off from work for an extended period of time to care for that family member, and taking extended time off work creates a financial hardship for the employee because he or she has exhausted all of his or her sick leave and other paid time off."

Make a copy for yourself. Return this signed form and all appropriate documentation to Mark Tomes, CCFT Catastrophic Leave Bank Committee Chairperson, c/o DSPS, P.O. Box 8106, San Luis Obispo, CA 93403-8106.

CCFT Use Only:

Date Rec'd: _____ Membership Eligibility Verified Date / By: _____

Date Committee Met: _____ ☐ Approved ☐ Denied

Date Notified Employee: _____ Date HR Notified: _____



**Application for Catastrophic Leave Bank Credits
Employee Statement Explaining Why Unable to Work
for an Extended Period of Time**

Employee Name: _____ Social Security Number or Banner Id: _____

Also complete the following if applying for catastrophic leave credits because you are unable to work due to a family member's catastrophic illness or injury:

Family Member's Name: _____ Family Member's Birth Date: _____

Relationship to Employee: _____

To the employee:

An employee applying for catastrophic leave credits must provide a statement explaining why he or she is "unable to work due to the employee's or his or her family member's catastrophic illness or injury."

Please explain below or on an attached page why you are unable to work for an extended period of time by addressing the following Education Code 87045(a)1 definition of "catastrophic illness or injury":

"an illness or injury that is expected to incapacitate the employee for an extended period of time, or that incapacitates a member of the employee's family which incapacity requires the employee to take time off from work for an extended period of time to care for that family member, and taking extended time off work creates a financial hardship for the employee because he or she has exhausted all of his or her sick leave and other paid time off."

Signature

Today's Date

Make a copy for yourself. Return this signed form and all appropriate documentation to Mark Tomes, CCFT Catastrophic Leave Bank Committee Chairperson, c/o DSPS, P.O. Box 8106, San Luis Obispo, CA 93403-8106.

CCFT Use Only:

Date Rc'd: _____ Verified by: _____



**Cuesta College Verification
of Use of Sick Leave and Other Accrued Paid Leave**

Employee Name: _____ Social Security Number: _____

To the Director of Human Resources:

An employee of the San Luis Obispo County Community College District (Cuesta College) has applied for a “catastrophic leave” benefit as provided by California law (Education Code 87045) and administered by the Cuesta College Federation of Teachers and Cuesta College. An employee may apply for the benefit on his or her own behalf or for the purpose of caring for a member of the employee’s family.

As part of the application process, the employee is required to provide verification that he or she has exhausted or will soon exhaust all of his or her sick leave, paid time off, and all other accrued paid leave credits (Education Code 87045 (a)1 and (b)3).

Director of Human Resources Certification:

I have verified that the employee named above has exhausted or will have exhausted all of his or her sick leave, paid time off, industrial accident or injury leave, and all other accrued paid leave credits by the date specified below.

Date that all leave time (as defined above) will be exhausted by the faculty member: _____

Director’s Signature

Today’s Date

Director’s Printed Name

Faculty member: make a copy for yourself. Return this signed form and all appropriate documentation to Mark Tomes, CCFT Catastrophic Leave Bank Committee Chairperson, c/o DSPS, P.O. Box 8106, San Luis Obispo, CA 93403-8106.

CCFT Use Only:

Date Rcd: _____ Verified by: _____



Physician's Verification of Catastrophic Illness

Employee Name: _____ Patient Name (if different): _____

Patient Birth Date: _____ Relationship to Employee: _____

To the Physician:

An employee of the San Luis Obispo County Community College District (Cuesta College) has applied for a "catastrophic leave" benefit as provided by California law (Education Code 87045) and administered by the Cuesta College Federation of Teachers and Cuesta College. An employee may apply for the benefit on his or her own behalf or for the purpose of caring for a member of the employee's family. As part of the application process, the employee is required to provide verification of the "catastrophic illness or injury."

Please review the definition of "catastrophic illness or injury" below prior to completing and signing this form.

CCFT, Cuesta College, and physicians are required to use Education Code 87045(a)1 definition of "catastrophic illness or injury" for the purposes of applying for leave credit donations. The 1997 Code defines these as

"an illness or injury that is expected to incapacitate the employee for an extended period of time, or that incapacitates a member of the employee's family which incapacity requires the employee to take time off from work for an extended period of time to care for that family member..."

A physician is required to apply the standard medical definition of "incapacity" to the patient's medical condition.

Physician's Certification:

As the physician who is responsible for the care of the patient named above, I certify it to be my medical opinion that the patient's condition satisfies the definition of the law in order to be considered a "catastrophic illness or injury" (see definition above). In the circumstance where the employee is a member of the employee's family, I further certify that the patient's condition requires that the employee take time off from work to care for the family member.

Physician, please show the **date** the illness or injury began and **describe** the nature and extent of the catastrophic illness or injury (attach supporting documentation, if necessary):

It is my medical opinion that the patient will be able to return to work (or the employee will no longer be required to care for the family member) as of _____
Date (not to exceed 12 months from today's date)

Physician's Signature

Today's Date

Physician's Printed Name

Business Street Address or P.O. Box

Physician's Telephone Number

Business City, State ZIP

Faculty member: make a copy for yourself. Return this signed form and all appropriate documentation to Mark Tomes, CCFT Catastrophic Leave Bank Committee Chairperson, c/o DSPS, P.O. Box 8106, San Luis Obispo, CA 93403-8106.

CCFT Use Only:

Date Rc'd: _____ Verified by: _____