Cuesta College Federation of Teachers AFT Local 4909

Strength Through Unity

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.

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.

☐ 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.

☐ 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."

Faculty member: make a copy for yourself. Return this signed form and all appropriate documentation to Heather Tucker, CCFT Catastrophic Leave Bank Committee Chairperson, c/o Nursing & Allied Health Division, 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: _____

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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

Faculty member: make a copy for yourself. Return this signed form and all appropriate documentation to Heather Tucker, CCFT Catastrophic Leave Bank Committee Chairperson, c/o Nursing & Allied Health Division, P.O. Box 8106, San Luis Obispo, CA 93403-8106.

CCFT Use Only:

Date Rec'd: _____ Verified by: _____

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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 Heather Tucker, CCFT Catastrophic Leave Bank Committee Chairperson, c/o Nursing & Allied Health Division, P.O. Box 8106, San Luis Obispo, CA 93403-8106.

CCFT Use Only:
Date Recd: _____ Verified by: _____

Cuesta College Federation of Teachers AFT Local 4909

Strength Through Unity

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 1994 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 patient 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 Heather Tucker, CCFT Catastrophic Leave Bank Oversight Committee Chairperson, c/o Nursing & Allied Health Division, P.O. Box 8106, San Luis Obispo, CA 93403-8106.

CCFT Use Only:
Date Rec'd: _____ Verified by: _____

This document, and any supporting documents, shall be treated as a confidential medical record(s); it shall not be placed in the employee's personnel file. Only those individuals with a need to know information will be given access to it. Any employee who fails to appropriately safeguard the confidentiality of this information will be subject to disciplinary action.

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Authorization Form for Release of Medical Records and Information

A. Identification: This document authorizes the use and/or disclosure of confidential protected health information about the following person or their authorized relative as allowed by this policy:

Employee Name: _____

Patient Name (If different from above): _____ Date of Birth: _____

B. Directions for Release:

I authorize the individual or company identified below in Section B. 1b to release and/or use protected health information pertaining to the individual listed in Section A as "Patient" to the individual(s) identified in Section B. 1a.

B. 1a. **I authorize the disclosure of information to**:

Cuesta College Human Resources Department

Members of the CCFT Catastrophic Leave Bank Oversight Committee

B. 1b. **I authorize the obtaining of information from**:

_____ (Specify Health Care Provider)

B.2 **Information to be released**: I authorize the disclosure and/or use of any information from my medical records relating to the condition(s) for which I am seeking leave.

B.3 **Purposes**: I authorize the disclosure and/or use for the following reason:
To determine my eligibility for participation in the CCFT Catastrophic Leave Bank benefit and for the disbursement thereof.

C. Right to Revoke: I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance upon it. This authorization will expire one year after the date it is signed. To revoke the authorization, I must contact, in writing, Heather Tucker, Chair, CCFT Catastrophic Leave Bank Oversight Committee, c/o Nursing & Allied Health Division, P.O. Box 8106, San Luis Obispo, CA 93403-8106.

D. Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions in Section B. I understand that this information is voluntary, the information to be disclosed is protected by law and the disclosure will conform with my directions.

I have read the contents of this authorization and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____	_____	_____
Your Signature	Printed Name	Date Signed