COUNTY OF YOLO
Catastrophic Leave Bank Program

APPLICATION for DONATED LEAVE

Please type or print legibly

Case# ________________

Instructions Complete this form to apply for Donated Leave. Attach all appropriate documentation of the catastrophic illness/injury (as defined in the Catastrophic Leave Bank Program Procedure attached). Include the Physician's Certification for Catastrophic Leave and the Catastrophic Leave Bank Program Liability Agreement.	***NOTE*** **The award of Donated Leave is dependent upon its availability within the Catastrophic Leave Bank and the approval of the Catastrophic Leave Bank Committee. The program does not create any expectation or promise of continued employment.**

PART I – APPLICATION *(To be completed by applicant employee or designee.)*

Patient Name (May be Qualifying Family Member) (*Last, First, Middle Initial)*	Relationship to Employee

Employee's Name *(Last, First, Middle Initial)*	Employee ID #

Employee's Department	Employee's Job Title

Work Phone Number	Home Phone	Birthday: Month/Day/Year

Paid Disability Benefits

☐ Yes ☐ No I have applied for State Disability benefits (SDI)
☐ Yes ☐ No I have applied for County Disability benefits (CDI)
☐ Yes ☐ No I have applied for Paid Family Leave (PFL)

Applicant Certification

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

☐ 1. I have been affected by a medical condition described on the attached Physician's Certification.
☐ 2. I have, or will have, exhausted all Leave and Compensatory Time as of the date indicated.
☐ 3. I expect to be absent from work without paid leave because of this medical condition.
☐ 4. I am not now, nor have I been in the past twelve (12) months, on requirement for sick leave substantiation.
☐ 5. I have made application and am receiving Workers' Compensation Benefits in connection with this work-related condition.
☐ 6. I have made application but am not receiving Workers' Compensation Benefits in connection with this work-related condition.
☐ 7. I agree that any leave I accrue while on Donated Leave will be used prior to receiving additional Donated Leave.

Signature of Employee Receiving Donated Leave or His/Her Designee	If Designee, state your relationship to Employee	Date

PART II – SUPERVISORY VERIFICATION *(To be completed by Employee's Supervisor.)*

Action for Leave Abuse during past 12 months? ☐ 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.**

Is there any reason you believe this employee should not qualify for Donated Leave? ☐ Yes ☐ No **If Yes, please explain below.**

Signature of Supervisor	Supervisor's Name *(PRINT)*	Phone Number	Date

COUNTY OF YOLO

Catastrophic Leave Bank Program

APPLICATION for DONATED LEAVE (continued)

Employee/Applicant Name *(Last, First, Middle Initial)*	Case #

PART III – HUMAN RESOURCES VERIFICATION

Employee FTE	Service Date	Probationary ☐ Yes ☐ No	Date Leaves Exhausted	Last Day Worked

Amount of Donated Leave Requested	**Beginning Date of Catastrophic Leave Request**	**Projected Ending Date**

WORKERS' COMPENSATION STATUS

Applied Date	Approved? Date	Pending?	Denied? Date
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DISABILITY INSURANCE STATUS

Does the applicant qualify for State Disability Insurance, County Disability Insurance or Ca. Paid Family Leave? ☐ Yes ☐ No	Has employee filed for coverage? ☐ Yes ☐ No	Anticipated duration of disability insurance.

Human Resources Designee Signature	Human Resources Designee Name *(PRINT)*	Phone Number	Date

PART IV – CATASTROPHIC LEAVE BANK 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	COMMENTS/ADVISEMENTS
Signature of Catastrophic Leave Bank Committee Designee		

DECISIONS RENDERED BY THE CATASTROPHIC LEAVE BANK COMMITTEE ARE FINAL AND NOT SUBJECT TO APPEAL

PART V – ACKNOWLEDGEMENT OF PROCESSING BY PAYROLL

Signature of Payroll Designee	Date	
Retain original in Payroll Forward copy to Applicant Employee	Total Hours Credited	Payroll Period Processed