CATASTROPHIC LEAVE REQUEST FORM
FOR STAFF EMPLOYEES

Employee Name (Last, First)

Employee ID Number

Home Dept Name

Preferred E-mail

Preferred Number

TO BE COMPLETED BY EMPLOYEE

Last day worked: Last day on pay status:

Anticipated dates you will be needing donations?
From: Thru:

Expected return to work date?

According to provisions of the Catastrophic Leave Program, I hereby request donated leave, in the amount of **Hours**.

Type of Leave:

Supervisor Name (Last, First):

Supervisor E-mail:

Supervisor Phone Number:

Timekeeper Name (Last, First):

Timekeeper Email:

Timekeeper Phone Number:

My signature below certifies that:

1. A leave of absence will need to be approved by my Department/Unit;
2. I will be required to exhaust all of my sick leave, vacation, PTO and compensatory time accruals;
3. I am not currently nor will I be receiving disability benefits or workers' compensation payments;

Employee's Signature **Date**

Supervisor's or Designee's Signature **Date**

(*The supervisor does not sign this application as an approval or denial, but as an acknowledgement*)

DEPARTMENT NOTIFICATION

I **do** authorize the use of my name in requesting donations of vacation/PTO leave from fellow UCI employees.

You must sign below to authorize the release of your name*

Employee's Signature **Date**

***If the employee requesting donations does not sign above, the employee's name will not be released.**

TO BE COMPLETED BY HUMAN RESOURCES

Authorizing Signature Date

Questions/Forms should be directed to Human Resources:
For Campus/Health Sciences: wcdm@uci.edu or call (949) 824-9152
For Medical Center: mcwcdm@uci.edu or call (714) 456-5736

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