APPLICATION
CATASTROPHIC LEAVE PROGRAM

Name: Employee ID #: _____

Department Name: Department Number: _____

Pony Number:

Phone Number (Home): _____ (Work): _____

To be eligible you must check all 4 boxes.

☐ I am a full or part-time permanent employee and

☐ I or a member of my family (including spouse, parent, domestic partner or adult dependent to age 30) have sustained a serious illness, injury or condition and

☐ I have exhausted all paid time off or will do so by: _____ and

☐ I will be unable to work for 30 days and have applied for a leave of absence without pay for medical reasons. **Attached is a copy of my Leave of Absence Form.**

I filed for SDI (State Disability) on: _____
I filed for Expanded Disability Benefit on : _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

☐ APPROVED ☐ DENIED Date: _____

_____ _____
Department Head Name Department Head Signature

Reason for Denial: _____

_____

<u>Important Note:</u> If this application has been denied by the department head it should be immediately returned to the applicant. The applicant may request a review of this denial by the Director of the Human Resources Department and the County Manager; please mail the request to Pony HRD133.