APPLICATION
CATASTROPHIC LEAVE PROGRAM

Name: _____ Employee ID #: _____

Department Name: _____ Department Number: _____

Pony Number: _____

Phone Number (Home): _____ Phone Number (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, _____, request to participate in the County's Catastrophic Leave Program. I am making this request because a family member or I have a serious illness or condition. (Please describe the qualifying condition. If necessary, as requested by the department head, please supply medical verification of the condition described below):

_____

_____

_____

_____ _____

Employee Signature Date

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

☐ APPROVED ☐ DENIED

_____

Date

_____ _____

Department Head Name (Print) Department Head Signature

Reason for Denial: _____

_____

Important Note: 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.