CATASTROPHIC LEAVE DONATION GUIDELINES

The Catastrophic Leave Donation Program is intended to provide a recipient employee with donated leave credits. To qualify for this program, the recipient, employee, must have a catastrophic illness or injury. The medical substantiation should indicate that the condition has caused total incapacitation from work. The condition can be considered catastrophic if due to, but is not limited to, Cancer, AIDS or residual effects of a stroke. Conditions which are short term in nature, such as colds, flu, or minor injuries, are generally not deemed catastrophic.

Catastrophic illness/injury also includes an incapacitating condition of an immediate family member which requires the employee to take an extended period of time off to care for him/her. An immediate family member is defined in employee’s collective bargaining agreement. Non-represented employees should contact Human Resources.

EMPLOYEE REQUEST FOR PARTICIPATION

I would like to participate as a recipient in the CSU, East Bay Catastrophic Leave Donation Program. I have read the guidelines and elect participation in the program. I hereby authorize the treating physician to release the required information requested below to California State University, East Bay for purposes of determining my eligibility for participation.

Employee Name:      Employee ID: ____________ Home Phone: _________  Department:_________
Extension:    _____Address:____________________________________________________________________

I understand that:

- I must be eligible to accrue vacation and/ or sick leave.
- I must be on an approved leave of absence.
- I must apply for Non-Industrial Disability Insurance, if eligible to apply for the leave program.
- I must provide a certification from the physician for myself or my immediate family member [as defined by appropriate Memorandum of Understanding (MOU)]. The certification will also provide an estimated return-to-work date.
- I must exhaust all allowed paid leave credits before I am eligible to receive donated leave credits.
- Participation in the Catastrophic Leave Program is subject to the provisions outlined in the Catastrophic Leave Donation Program Policy, therefore, reserving the right to make a determination based on a case by case basis.

__________________________________________  ______________
Employee Signature (or Designee)             Date

Human Resources use only:  __ Approved      Not Approved

CATASTROPHIC LEAVE APPROVED: ____________ TO ____________   ____________ TO ____________
________________________________________
Signature of Coordinator      Date                                 Date copy forwarded to Payroll  ___________

PHYSICIAN CERTIFICATION

As treating physician for the above-named employee (or employee’s immediate family member), I hereby certify that the employee (or employee’s immediate family member) has a catastrophic illness or injury as defined by the above guidelines:

Physician’s Name (Please Print): __________________________________________ Phone:_______________________
Address:  ___________________________________________________________________________________  _____
Type of Practice:_________________________ Estimated Period of Recovery:_________________________
Signature of Treating Physician: __________________________________________ Date: _______________________

Note: HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS WITHOUT CONSENT OF PATIENT. 04/2011