CALIFORNIA STATE UNIVERSITY EAST BAY

Catastrophic Leave Donation Program Request and Certification Form

Human Resources, 25800 Carlos Bee Blvd., SA 2600, Hayward, CA 94542
Office 510-885-3634 Fax 510-885-2951

Instructions: Please complete the employee portion of the form and submit to the treating physician to complete *Physician Certification* section. Submit completed form to Human Resources, SA 2600.

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 membe**r 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.

Catastrophic Leave Donation Program Request for: ☐ Self ☐ Immediate Family Member

If immediate family member: _____
Patient's Name (if Family Member) Relationship to Employee

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