**UCOP Catastrophic Leave Sharing Program**

**Recipient Application Request**

Date:

Recipient’s Name (printed):       Employee ID #:

Department:       Phone #:

Have you received Catastrophic Leave in the previous 12 months? No  Yes  Date:

Number of hours requesting:       Dates of Leave: From       to

(Maximum is 160 hours)

Do you authorize the use of your name in requesting donations of vacation from fellow UCOP employees?

Yes

No

Check the appropriate reason(s) for leave hours:

Catastrophic Illness or Injury

Death of a Family Member

Catastrophic Event (loss due to terror attack, fire or natural disaster)

I understand that:

* I must be a staff employee who is eligible to accrue and use vacation.
* I must be on an approved leave of absence.
* I understand that UCOP Local Human Resources will request appropriate documentation to verify my request.
* I must exhaust all paid leave credits (sick, vacation, and CTO) before I am eligible to receive donated leave;
* In order to use donated vacation hours, I may not be on any other University pay status, receiving University (Liberty Mutual) disability, or have filed for Worker’s Compensation benefits.
* My participation in the Catastrophic Leave Sharing Program is subject to provisions outlined in the guidelines.
* Any unused hours must be returned to the Bank.

*Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part Two: TO BE COMPLETED BY UCOP Local Human Resources**

Has all vacation, sick leave and compensatory time (if applicable) been exhausted?

Yes  No  Pending  If pending, please explain:

Expected Return to Work Date:

Have the reasons for Catastrophic Leave been verified? Yes  No

**Accommodation and Leave Manager’s Signature (or designee):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Name (please print) Signature Date