**CATASTROPHIC LEAVE REQUEST**

TO BE COMPLETED BY EMPLOYEE

|  |  |  |  |  |  |  |  |  |  |  |  |
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| **EMPLOYEE INFORMATION** | | | | | | | | | | | |
| Employee Name: | | | |  |  | Department: | | | | |  |
| UW System Title: | | | |  |  | FTE %: | | | | |  |
| Working Title: | | | |  |  | Supervisor: | | | | |  |
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| **CRITERIA** | | | | | | | | | | | |
| You must meet all the following criteria to be considered for the Catastrophic Leave Program *(see* [*UPS OP BN 5*](https://www.wisconsin.edu/ohrwd/download/policies/ops/bn5.pdf) *for more information)*   * Must be on an approved unpaid leave of absence due to a catastrophic need\*; * Have exhausted all available leave, including sick leave; * Must not be receiving other salary replacement income (e.g. workers compensation, income continuation, unemployment, social security, private insurance, replacement income from other employment). * Complete this form (or provide a written request) with sufficient information to determine catastrophic need to Human Resources. You may be contacted for further information as needed. * You may not receive salary replacement income or benefits such as Income Continuation Insurance, social security or Worker’s Compensation while receiving leave donation.   \*Catastrophic need means a significant financial hardship that is due to an illness, medical condition, or injury that incapacitates or is expected to incapacitate an employee or an employee’s family member that requires the employee to take unpaid time off from work for an extended period of time, as defined by the institution. | | | | | | | | | | | |
| Check the reason you are requesting Catastrophic Leave Hours and provide additional information, as requested. | | | | | | | | | | | |
|  | I have a catastrophic need due to my own illness, medical condition or injury for which I am on an approved unpaid leave of absence. | | | | | | | | | | |
|  | I have a catastrophic need due to a family member’s illness, medical condition or injury for which I am on an approved unpaid leave of absence. | | | | | | | | | | |
| Name of the person you are caring for: | | | |  | | | | | | | |
| Relationship: | | | |  | | | | | | | |
| Reason for Catastrophic leave if W/FMLA Certification is not on file: | | | |  | | | | | | | |
| Begin Date: | |  | | | | | End Date: | | |  | |
| Anticipated Catastrophic Leave hours needed: | | | | | | |  | | | | |
| Will you receive any salary replacement income?  No  Yes, indicate what type:  Income Continuation Insurance  Workers Compensation  Other: | | | | | | | Leave Type:  Continuous  Intermittent | | | | |
| I authorize the University of Wisconsin- Green Bay to obtain any necessary information regarding my request for catastrophic leave. | | | | | | | | | | | |
| Employee Signature: | | |  | | | | | Date: |  | | |
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| **FORWARD TO HUMAN RESOURCES FOR PROCESSING** | | | | | | | | | | | |