

**Central Michigan University  
Catastrophic Leave Bank Application**

(Note: This application can be initiated by the employee or another individual if the employee is incapacitated.)  
see guidelines @ <http://www.cmich.edu/x10285.xml> Questions: 774-6447

**All sections of this application must be completed BEFORE submitting to Human Resources.**

|                         |  |                             |                     |
|-------------------------|--|-----------------------------|---------------------|
| <b>Employee Name</b>    |  |                             |                     |
| <b>Personnel Number</b> |  | <b>Date of Hire (MM/YR)</b> |                     |
| <b>Employee Group</b>   |  | <b>Department</b>           |                     |
| <b>Campus Address</b>   |  |                             | <b>Campus Phone</b> |
| <b>Home Address</b>     |  |                             | <b>Home Phone</b>   |

|  |  |  |
|--|--|--|
| <b>Leave Bank Hours Requested</b>                          |  | <i>NOTE: Not to exceed 80 hrs per calendar year-prorated for part time</i> |
| <b>Date(s) hours will be used</b>                          |  |  |
| <b>Date leave balances are anticipated to be exhausted</b> |  |  |
| <b>Do you have Short Term Disability? YES NO</b>           |  |  |
| <b>Family member name, if family member illness</b>        |  |  |
| <b>Relationship to employee</b>                            |  |  |

|   |  |
|---|--|
| <b>Name (printed) of health care provider</b> |  |
| <b>Address-health care provider</b>           |  |
| <b>Phone number-health care provider</b>      |  |

**MEDICAL CERTIFICATION FORM MUST BE ATTACHED: <http://www.cmich.edu/x4754.xml>**

1. I give my permission, if necessary, for the Human Resources Department to verify or request additional information and/or documentation from my attending health care provider.
2. I give permission to the University to share my medical information with the committee members. I understand that committee members are obligated to keep this information confidential.
3. I certify that all information on this application is correct.
4. I understand the decision of the Serious & Catastrophic Leave Committee is final.
5. I agree to comply with the requirements of the Serious & Catastrophic Leave Bank policy.

|   |  |             |  |
|---|--|-------------|--|
| <b>Employee/Designee Signature</b>                  |  | <b>Date</b> |  |
| <b>If Designee, state relationship to employee:</b> |  |             |  |

**TO BE COMPLETED BY THE SUPERVISOR**

I have knowledge the above employee is making application to the Serious & Catastrophic Leave Bank

|                               |  |             |  |
|-------------------------------|--|-------------|--|
| <b>Supervisor's Signature</b> |  | <b>Date</b> |  |
|-------------------------------|--|-------------|--|

Submit completed application to: Human Resources/Employee Relations, Rowe 114

Applications **MUST BE COMPLETED** and **SUBMITTED** to Human Resources within 10 working days prior to anticipated expiration of all leave time.

**TO BE COMPLETED BY THE SERIOUS & CATASTROPHIC COMMITTEE**

|  |                 |  |                                   |             |
|--|-----------------|--|-----------------------------------|-------------|
| <b>Request has been:</b>                 | <b>Approved</b> |  | <b>Number of leave bank hours</b> |             |
|  | <b>Denied</b>   |  | <b>Reason:</b>                    |             |
| <b>Signature-Chair of SCL Committee:</b> |                 |  |                                   | <b>Date</b> |