LOS RIOS COMMUNITY COLLEGE DISTRICT

IMMEDIATE FAMILY CATASTROPHIC LEAVE APPLICATION

Los Rios Faculty

Instructions: Employee or representative is to complete this form and attach the Physician's Statement and the Authorization for Release of Medical Information form. All forms are to be returned to the Vice Chancellor, Human Resources @ brayc@losrios.edu and LRCFT President @ newmanj@crc.losrios.edu

Employee Name _____ Employee ID # _____

To be eligible for Immediate Family Catastrophic Leave, you must confirm of all the eligibility requirements listed below are true by checking each box provided.

☐ I wish to apply for the Immediate Family Catastrophic Leave available per Article 9.4.5 of the LRCFT Contract.

☐ I am a permanent full-time faculty member of the District.

☐ I have an immediate family member who has a catastrophic illness or injury that is expected to incapacitate them and requires me to be present during the period of critical illness or injury.

☐ I have exhausted, or will exhaust before using this leave, all my Personal Necessity Leave (Article 9.4.1), Critical Illness Leave (Article 9.4.4), and Personal Business Leave (Article 9.9), and I am, or will still be, unable to return to work, either partially or fully, due to a catastrophic illness or injury of my immediate family member.

☐ Due to the catastrophic illness or injury of my immediate family member, I am, or will be, in less than full pay status.

☐ I have not received Immediate Family Catastrophic Leave during the current work year.

☐ I understand that I must attach a completed **Immediate Family Catastrophic Leave Physician Statement** to my application to be considered.

☐ I understand that the Catastrophic Illness or Injury Committee is charged with oversight of the Immediate Family Paid Employee Catastrophic Leave program, including approval or disapproval of applications. The decisions of the Committee shall be final. Committee deliberations are confidential.

ONLY CHOOSE ONE:

Option 1:

☐ I understand that in the case of critical illness or injury of a member of my immediate family, I am requesting full leave, and I am requesting to use this program to receive 50% of my regular salary and keep my current level of medical benefits during my leave. This leave can be for a maximum of 4 weeks in a row, with each week defined as 7 consecutive days. I understand that the remaining 50% of my regular salary will be unpaid and this could impact my retirement service credit. I am requesting full leave at 50% of my regular salary from _____ to _____.

Option 2:

☐ I understand that in the case of critical illness or injury of a member of my immediate family, I am requesting partial leave, and I am requesting to use this program to supplement my regular salary up to 50%, making my total salary no more than 100% of what I usually earn. I will continue to receive my current level of medical benefits. This leave can be for a maximum of 4 weeks in a row, with each week defined as 7 consecutive days. I understand that the time that I am not working, that is not covered by this leave program, will be unpaid and could impact my retirement service credit. I am requesting partial leave at _____% of my regular workload from _____ to _____.

I verify my eligibility for application by affirming the truth of all the eligibility criteria mentioned above. I am requesting approval for the Immediate Family Paid Catastrophic Leave. Attached to this request is a physician's statement confirming the critical illness or injury of a member of my immediate family.

Employee Name (please print)_____

Employee Signature_____Date_____

Committee Use Only:

☐ *Approved for ___ weeks at ___% pay*

☐ *Denied Reason _____*

Start Date _____ End Date _____

_____ _____

Signature – Vice Chancellor, HR *Date*