LOS RIOS COMMUNITY COLLEGE DISTRICT

EXTENDED 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 Extended Paid 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 Extended Paid 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 a Catastrophic illness or injury, which is an illness or injury that is expected to incapacitate me from work.

☐ I have exhausted all my eligible leave balances, and I am still unable to return to work, either partially or fully, due to a catastrophic illness or injury.

☐ I am not eligible for disability workers' compensation, or other benefits.

☐ Due to my catastrophic illness or injury, I will or am in less than full pay status.

☐ I understand that I may apply for up to eighty-two (82) workdays of leave commencing the first day that I am in less than full pay status and ending no more than 82 days later.

☐ I understand that I must attach completed Extended Catastrophic Leave - Physician Statement and the Authorization for Release of Medical Information for my application to be considered.

☐ If I wish to apply for an extension, I understand I must submit a new application with supporting documentation.

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

I verify my eligibility for application by affirming the truth of all the eligibility criteria mentioned above. I am requesting approval for the Extended Paid Catastrophic Leave. Attached to this request is a physician's statement confirming my illness or injury, along with the Authorization for Release of Medical Information form.

Employee Name (please print)_____

Employee Signature_____ Date_____

Committee Use Only:

Leave: ☐ Approved for _____ days. ☐ Denied_____
Reason

Start Date _____ End Date _____

_____
Signature – Vice Chancellor, HR Date