Santa Maria Joint Union High School District
CSEA CATASTROPHIC LEAVE REQUEST

EMPLOYEE:

Print Name:_____ ID:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Physician's Name:_____ Physician's Phone_____

Physician's Address:_____

I hereby authorize the Classified School Employees Association, Chapter #455 to contact the above-named physician in order to obtain the information on the attached Physician's Certification relevant to the Catastrophic Leave Committee's evaluation of this Catastrophic Leave Request. I understand that catastrophic leave will run concurrent with Family Medical Leave, and I must exhaust all other leaves prior to the receipt of donated time (CSEA §8.11.5.1).

Employee Signature:_____ Date:_____

Or

Representative Signature:_____ Date:_____

☐ Check here if the request relates to a member of the employee's family. The family member must sign this form authorizing the release of the information on the attached Physician's Certification unless the family member is the minor child of the employee. In addition, the employee must attach a statement to this form indicating the circumstances that require the employee's absence from work.

Name of Family Member:_____ Minor Child? ___Y ___N

Relationship to Employee:_____

Signature of Family Member:_____ Date:_____

☐ Initial Request (maximum of 30 days) ☐ Extended Request (additional 30 days)

First Day Off Work:_____ Anticipated Return Date:_____

NOTE: *All requests must be signed by the employee (and family member if applicable) and must include a completed Physician's Certification.*