

MADERA UNIFIED SCHOOL DISTRICT

HUMAN RESOURCES DEPARTMENT

CATASTROPHIC LEAVE APPLICATION

EMPLOYEE NAME: _____

SSN# XXX-XX-_____

JOB TITLE: _____

SITE/DEPT: _____

I hereby request to participate in the Madera Unified School District's **Catastrophic Leave Program**, which allows me to receive sick leave donations from employees while on a catastrophic leave of absence pursuant to Education Code 44043.5 and Board Policy 4161.9.

I understand that in order to be eligible to receive catastrophic leave donations, I must satisfy the following:

- Employee or the employee's family member is suffering from a catastrophic illness or injury that is expected to incapacitate him or her for an extend period of time.
- Be on an approved medical leave for an extended period of time.
- Have submitted medical certification to the Human Resources Department.
- Have exhausted all accrued paid time off.
- Extended time off will create a financial hardship for myself.

I certify that I have met the eligibility requirements listed above and request approval to receive donations.

Employee Signature

Date

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[To be completed by Human Resources](#)

☐ Qualifies

☐ Does not Qualify for the following reason: _____

Human Resources Authorized Signature

Date