CAL MARITIME

Catastrophic Leave Donation Program

Instructions: Please complete the employee portion of this form and submit to your treating physician to complete the ***Physician Certification*** section. Submit the completed form to the Benefits Coordinator in Human Resources.

The Catastrophic Leave Donation Program is intended to provide an employee with a catastrophic illness or injury, and who has exhausted or will exhaust her/his own leave credits, with donated leave credits from other CSUM employees. The medical substantiation from the treating physician should indicate that the condition has caused total incapacitation from work. The condition can be considered catastrophic if due to, but is not limited to, Cancer, AIDS, residual conditions from a stroke or heart attack, or a serious chronic condition that incapacitates the employee from working. Conditions which are short term in nature, such as colds, flu, or minor injuries, are not deemed catastrophic.

Catastrophic illness/injury also includes an incapacitating condition of an **immediate family member** which requires the employee to take an extended period of lime off to care for the family member.

Employee Request for Participation

I would like to participate as a recipient in the Cal Maritime Catastrophic leave Donation Program. I have read the guidelines and elect participation in the program. I hereby authorize the treating physician to release the required information requested below to California Maritime Academy for the purpose of determining my eligibility for participation.

Catastrophic Leave Donation Program Request for: ☐ Self ☐ Immediate Family Member

If immediate family member: _____

Patient's Name (if Family Member) Relationship to Employee

_____

Employee Name Department Campus Phone Home Phone

I understand that:

- I must be eligible to accrue vacation and/or sick leave
- I must be on an approved leave of absence
- I must apply for Non-Industrial Disability (NDI) Insurance, if eligible, to apply for the Catastrophic leave program
- I must provide a certification from the physician for myself or my immediate family member (as defined by the appropriate collective bargaining unit or Memorandum of Understanding. The certification must also provide an estimated return-to-work date.
- I must exhaust ***all*** allowed paid leave credits ***before*** I am eligible to receive donated leave credits.

_____ _____

Employee Signature (or designee) Date

Human Resources use only: ☐ Approved ☐ Not Approved If approved: From_____To_____

Date request for donations went to campus: _____ _____

Benefits Coordinator's Signature

PHYSICIAN CERTIFICATION

As treating physician for the above-named employee (or employee's immediate family member), I hereby certify that the employee (or employee's immediate family member) has a catastrophic illness or injury.

Printed Name of Physician:_____Phone: _____

Address: _____

Type of Practice: _____Estimated Period of Recovery: _____

Signature of Treating Physician:_____Date:_____

NOTE: THE HEALTH CARE PROVIDER IS NOT TO DISCLOSE THE MEDICAL CONDITION.