Leave Bank and Catastrophic Leave*
Request Form
Mulvane USD #263

*Catastrophic leave is available only to the employee.

This form is for the Leave Bank Committee, which consists of a Central Office staff member and three representatives from the Mulvane Education Association. This form is intended to assist the committee in making an informed decision, and all information will remain confidential.

Name: _____ **Title:** _____ **Date:** _____

I am requesting

- ☐ Leave Bank Days due to a serious health condition (must include a doctor's note)
  - ☐ for which I need care.
  - ☐ affecting my
    - ☐ spouse ☐ child ☐ parent, for which I am needed to provide care
- ☐ Leave Bank Days due to
  - ☐ parental leave (can use up to 10 days)
  - ☐ bereavement leave (can use 2 days)
  - ☐ other (please describe) _____
    _____
- ☐ Catastrophic Leave due to a serious health condition for which I need care.
  - The Certification of Catastrophic Illness form must be filled out by a Healthcare Provider and attached to this application (see page 2).
  - A catastrophic illness is a period of incapacity which is permanent or long-term due to a condition for which treatment may or may not be effective. The employee must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include but may not be limited to Alzheimer's, a severe stroke, or the terminal stages of a disease.

If you are requesting Leave Bank days, you are eligible for 10% of the number of days in the bank (this number varies from year to year). If you are requesting Catastrophic Leave, you may request up to 30 days.

Number of days requested: _____

Beginning leave date: _____ **Continuing until:** _____

Employee Signature: _____

Certification of Catastrophic Illness
Mulvane USD #263

(Must be completed by a healthcare provider.)

Patient's Name _____

The above patient is applying for catastrophic sick leave from his/her place of employment. A catastrophic illness is considered to be: a period of incapacity which is permanent or long-term due to a condition for which treatment may or may not be effective. The employee must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include but may not be limited to Alzheimer's, a severe stroke, or the terminal stages of a disease.

1. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the above criteria:

2. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity, if different):

3. Will it be possible for the employee to take work intermittently or to work on a less than full schedule as a result of the condition?

_____ _____

Signature of Healthcare Provider Date

_____ _____

Address Phone Number