CATASTROPHIC LEAVE PROGRAM APPLICATION FORM

Name: _____ Employee ID #: _____

Department: _____ Department No: _____ PONY: _____

Phone Number (Home) _____ (Work) _____

To be eligible you must check all 4 boxes.

☐ I am a full or part-time permanent employee and

☐ I or a member of my family (including spouse, parent, domestic partner or adult dependent to age 30) have sustained a serious illness, injury or condition and

☐ I have exhausted all paid time off and payment from SDI, PFL or any other income source or will do so by _____(date) and

☐ I will be unable to work for 30 days and have applied for a leave of absence without pay for medical reasons.

Attached is a copy of my Leave of Absence Form.

I filed for SDI (State Disability) on:_____

I filed for Expanded Disability Benefit on: _____

Signature:_____ Date: _____

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

☐ **APPROVED**

Completed donation forms are sent directly to the recipient's department and signed by the Department Head. Please provide the instructions for submitting the completed forms:

"Upon completion, please forward the donation form directly to the receiving employee's department, ATTN: _____, via PONY _____ or attach the completed form and send it via email to: _____@smcgov.org."

☐ **DENIED** Reason for Denial: _____

_____ _____

Department Head Name and Signature Date

IMPORTANT NOTE: If this application has been denied by the department head it should be immediately returned to the applicant. The applicant may request a review of this denial by the Director of the Human Resources Department and the County Manager; please mail the request to Pony HRD133.