CATASTROPHIC LEAVE PROGRAM
EMPLOYEE INFORMATION

The Catastrophic Leave Bank Program is a State employee benefit established by Arkansas Code Annotated 21-4-214 et seq. The purpose of the program is to provide paid leave for employees with a catastrophic illness who have exhausted all other paid leave. **Catastrophic illness, as defined by the State, means a personal emergency limited to catastrophic and debilitating medical situations, severely complicated disabilities, and severe accidental injuries which cause the employee to be incapacitated from the performance of assigned job duties, which require a prolonged period of recuperation, and which require the employee's absence from duty as documented by a physician or other individual as provided in ARK.CODE Annotated 21-4-201 et seq.** The University of Arkansas - Fayetteville Catastrophic Leave Bank is a pool of accrued leave donated by eligible employees that may be transferred to qualified recipients. Only the hours are transferred - the employee continues to be paid by the employing department while on Catastrophic Leave.

FMLA IMPLICATIONS:

The Family and Medical Leave Act (FMLA) of 1993 requires covered employers to provide up to twelve (12) weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. This includes serious health conditions, defined as an illness, injury, impairment, or physical or mental condition that makes the employee unable to perform the employee's job. Consequently, an employee with a medical condition that meets the definition of catastrophic illness under the Catastrophic Leave Bank Program, and who meets the eligibility requirements of the Catastrophic Leave Bank Program, also may meet FMLA eligibility requirements. **In addition to any other FMLA leave you have used (or any unused portion of your entitlement), all Catastrophic Leave time taken will reduce your twelve (12) week FMLA entitlement for the calendar year in which it occurs.**

Upon notification of a "FMLA eligible" situation, the FMLA requires employers to give employees written notice that their leave time in regard to the situation will be deducted from their twelve week FMLA entitlement. The information provided above serves as notice that your twelve-week FMLA entitlement will be reduced by the amount of any Catastrophic Leave time used by you.

Other types of leave could also reduce your FMLA entitlement. Please contact the Department of Human Resources at 575-5351 regarding your specific circumstances.

CATASTROPHIC LEAVE BANK PROGRAM ELIGIBILITY REQUIREMENTS:

- The recipient must be a current full-time state employee who has been employed by the State for at least two (2) years in a regular, full-time position. Service does not have to be continuous.
- The employee must not have been disciplined for misuse or inappropriate use of leave within the past two (2) years.
- The employee must have exhausted all accrued leave (annual, sick, holiday, and compensatory time).
- The employee must have a current "Physician's Certification" of a medical condition which prevents the employee from performing the employee's job duties for a prolonged period of time (defined as 20 working days) and which will result in a substantial loss of income.
- The employee must have at least an 80 hours combined sick and annual leave accrual at the onset of the illness or injury.

NOTE TO THE EMPLOYEE:

It is important that the employee, or their legal representative, file as soon as they know that they need Catastrophic Leave and their available leave is going to exhaust. **Follow-up on the processing of the application is the employee's responsibility.**

Employees on Catastrophic Leave continue to accrue leave and receive other benefits, however any leave earned while an employee is on Catastrophic Leave must, as a condition of voluntary participation in the program, be assigned to the Catastrophic Leave Bank, and any restrictions concerning the maintenance of minimum leave balances shall not apply to such assignment.

APPLICATION PROCEDURES:

1. Applicant should obtain and read the Catastrophic Leave Bank Program Rules and Regulations. This document has been sent to each Dean, Director, and Department Head on campus, and should be made available to applicants.

2. Obtain a current set of Catastrophic Leave forms from the Catastrophic Leave Bank Coordinator in Human Resources or from your department leave representative.
   (a) Liability Agreement
   (b) Recipient Application Form
   (c) Physician's Certification for Catastrophic Leave

3. Sign the Authorization to Release Information section of the Physician's Certification for Catastrophic Leave form, and have your physician complete the rest of this form explaining your current medical condition.

4. Complete employee portion of Part I of Recipient Application form and have your leave representative complete the leave portion. Complete Part IV of the Recipient Application form. Read and sign the Liability Agreement form.

5. The application forms - the completed Recipient Application Form, Physician's Certification for Catastrophic Leave, and the Liability Agreement - should be given to your supervisor. Your supervisor must verify on Part II of the Recipient Application form that the applicant has not been disciplined for misuse or inappropriate use of leave during the past two years and explain why the employee's leave has been exhausted. Supervisor should submit the completed signed application package to the Catastrophic Leave Bank Coordinator in Human Resources who will verify eligibility requirements have been met by the applicant, and the completeness of forms. The Coordinator will present the application to the Catastrophic Leave Bank Committee for review.

For additional information regarding this program, please contact Leah Williams, Catastrophic Leave Bank Coordinator, at 575-7618 or leahw@uark.edu.

University of Arkansas, Fayetteville

Catastrophic Leave Bank Program

Recipient Application Form

Please Type or Print Legibly

Authorized by A.C.A. 21-4-214 et.seq.

Case # _________

Instructions:	**Complete this form to apply for catastrophic leave time. Attach to this form all appropriate documentation of medical emergency such as the Physician's Certification for Catastrophic Leave and the Catastrophic Leave Bank Release from Liability. After completion of these procedures, present this form to your supervisor.**
Note:	**Catastrophic leave time is based upon availability within the University's Catastrophic Leave Bank. The program does not create any expectation of promise of continued employment.**

Part I – Application & Certification (To be completed by the applicant employee or designee on his/her behalf)

Name (Last, First, Middle Initial)	Position Number	Employee ID Number	Class Code of Position

Position Title	Grade	Hourly Rate of Pay	Name and Address of Assigned Duty Station

Work Phone #	Home Phone #	Birth Date	Date Leave Exhausted (includes Annual, Sick, Holiday and Comp) (verified by timekeeper)
		Mo. Day	Date Time a.m. p.m.

Amount of Catastrophic Leave Requested (Total Hours Requested in One (1) Hour Increments)	Duration Dates of Catastrophic Leave Request
	Beginning Date Projected Ending Date

Timekeeper's Name	Timekeeper's Signature	Phone Number	Date

Certification: (if certifying on behalf of an employee, modify as appropriate)

I certify that:

(1) I have been affected by a medical emergency, described on the attached Physician's Certificate.
(2) I have or will have exhausted all annual, sick, holiday leave and compensatory time as of date indicated above.
(3) I expect to be absent from duty without paid leave because of this medical emergency.
(4) I agree that any leave accrued while on catastrophic leave will be returned to the Catastrophic Leave Bank.

Signature of Recipient or His/Her Designee (please specify)	If Designee, State Your Relationship to Recipient	Date
Recipient:		
Designee:		

Part II – Supervisory Verification

To Be Completed by Employee's Supervisor

Disciplinary Action for leave abuse during past two years? Yes_______ No______	Why has this employee's leave been exhausted?
Could this job be restructured temporarily to allow employee to return to work at an earlier date? Yes_____ No_____	
Signature of Supervisor:	Date:

Part III – Personnel/Payroll Verification (To be completed by Department of Human Resources)

Full Time	Career Service Date	Last Hire Date	Workers' Compensation Status			
			Applied?	Approved?	Pending?	Denied?
Yes__ No___			Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___

Signature of Authorized Human Resources Representative	Position Title	Phone #	Date

Part IV – Explanation of Leave Usage (to be completed by the applicant)
Please provide a written explanation of leave usages resulting in low leave balances that necessitate the need for Catastrophic Leave. Include any extenuating circumstances or situations that have required large amounts of leave to be taken, as well as reasons for frequent leave use over the course of the past two years.

____

____

____