Dallas County

Catastrophic Leave Pool Request Form

Employee No:	**Employee Name:**
Job Title:	**Date of Hire:**
Department::	**Contact Ph. #:**

I request the transfer of leave from the Dallas County Catastrophic Sick and Vacation Leave Pool to my account. I certify that I have exhausted all paid leave to which I am entitled, and that I have read the policy and understand the conditions for requesting and using leave under the Dallas County Catastrophic Sick and Vacation Leave Policy.

COMPLETE THE FOLLOWING: (check the appropriate box)

☐ I am	☐ I am not	Suffering from a Catastrophic Illness or Injury as defined in the County Catastrophic Sick and Vacation Leave policy, which is not exempted from coverage. **If No, STOP HERE**. The condition(s) does not qualify for Catastrophic Leave.
☐ I am	☐ I am not	Currently receiving benefits from worker's compensation
☐ I am	☐ I am not	Currently receiving disability payments (including long term or short term) or voluntary supplemental insurance payment. If received on/after leave is approved, will notify HR Administrator and Payroll Division immediately.
☐ I have	☐ I have not	Received an award of Catastrophic Leave before. Date Received if applicable:

If requesting time to care for an eligible family member under the FMLA: Family member's name and relationship (including if in loco parentis): ____

____

The Catastrophic Leave Medical Certification Form has been completed by my physician (or my family member's physician) and is included with my CLP Application Request: ☐ YES ☐ NO

Reason for requesting leave from Catastrophic Sick and Vacation Leave Pool:

The Catastrophic Sick and Vacation Pool Policy requirements must be met for an award, and I understand that the decision of the Administrator concerning my request is final. If denied, I may still qualify for unpaid

FMLA or other leave options and should contact Human Resources to discuss all other available leave options. I certify that the representations made herein are true and correct and agree to notify the Administrator immediately (within 72 hours) if there is any change or modification in my Catastrophic Illness or Injury after an award, if any, resulting in a reduction in my need for Catastrophic Leave:

Employee Signature **Date**

TO BE COMPLETED BY ADMINISTRATOR:

The employee is ____ is not ____ eligible based on his/her ☐ length of service (12 continuous months), ☐ employment status (must be full-time non-probationary employee) ☐ illness or injury, ☐ documentation, ☐ compensatory time remaining after deduction (must be 80 hours of sick/vacation); and/or ☐ hours donated for fiscal year (minimum of eight hours). **All boxes must be affirmatively checked for the employee to be eligible**.

Date employee will exhaust all paid leave ______________________.

☐	I APPROVE the above request. Maximum number of hours approved in accordance with the policy is ________________ (may be reduced if not supported by follow-up documentation or circumstances change) starting on _____________________ and ending on ____________________________.
☐	I DENY the above request because:

Administrator Signature **Date**

Payroll Division Only	
Debit the Dallas County Catastrophic Leave Pool with _________ hours of leave. **Credit the employee's account:** Hours of Sick Leave: __________________	
Processed By(Print Name):	**Signature:**
Date Processed:	

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