

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 Leave Administrator at 575-7618 regarding your specific circumstances.

CATASTROPHIC LEAVE BANK PROGRAM ELIBIBILITY REQUIREMENTS:

- The recipient must be a current full-time 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 (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 prolong 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. The employee must have the completed application submitted to the Leave Administrator by the 1st working day of the month.**

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. No, retroactive hours will be granted to employees.

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 the 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 Coordinator in Human Resources who will verify eligibility requirements have been met by the applicant, and the completeness of forms. The completed application must be submitted to the Leave Administrator by the 1st working day of the month. The coordinator will present the application to the Catastrophic Leave Bank Committee for review.

For additional information regarding this program, please contact Wa'Nika Smith, Catastrophic Leave Bank Coordinator, at 575-7618 or wxs01@uark.edu

University of Arkansas, Fayetteville
Catastrophic Leave Bank Program
Recipient Application Form
 Authorized by A.C.A. 21-4-214 et.seq.

Please Type or
 Print Legibly

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 Mo. Day	Date Leave Exhausted Date Time a.m. p.m.	(includes Annual, Sick, Holiday and Comp) (verified by timekeeper)
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 Yes ___ No ___	Career Service Date	Last Hire Date	Workers' Compensation Status			
			Applied? Yes ___ No ___	Approved? Yes ___ No ___	Pending? Yes ___ No ___	Denied? Yes ___ No ___
Signature of Authorized Human Resources Representative			Position Title	Phone #	Date	

University of Arkansas, Fayetteville Catastrophic Leave Bank Program Liability Agreement

I have read and understand the rules and regulations of the Catastrophic Leave Bank Program.

Forfeiture of Benefits

I understand that I will forfeit the benefits of the University of Arkansas, Fayetteville Leave Bank Program by:

- Resignation or end of employment with the State of Arkansas.
- Any fraud or misrepresentation of facts in making application for leave from the Catastrophic Leave Bank (CLB).

I understand that alleged abuse of the CLB shall be investigated, and, on a finding of wrongdoing, I shall repay all of the leave hours drawn from the CLB and shall be subject to such other disciplinary action as is determined by my agency director/institution head.

Release from Liability

I understand that the Catastrophic Leave Bank Committee is not an agency, board, or other subdivision of the State of Arkansas. The Committee's decisions are not subject to grievance, arbitration, or litigation. Committee action may be appealed only to the Chancellor.

Signature of Recipient or Designee

Date

University of Arkansas, Fayetteville
State of Arkansas
Catastrophic Leave Bank Program
Physician's Certification for Catastrophic Leave

Name: _____
(Print or Type) Last First Middle

Address: _____
 Street City/State Zip

Authorization to Release Information: I hereby authorize the undersigned physician to release any and all information acquired in the course of my examination or treatment for the purpose of consideration by the Catastrophic Leave Committee.

(Date)

Employee's Signature
(or Legal Representative)

Brief Description of Employee's Job Duties: _____ _____ _____ _____ _____ _____ _____

**The employee is responsible for the completion of this form at his/her own expense.
All information listed on this form will be kept confidential.**

(To be Completed by the Attending Physician)

The following questions apply only to this illness/injury:

1. History
 - (a) When did illness/injury first appear? Month _____ Day _____ Year _____
 - (b) Could this illness/injury be work related? Yes _____ No _____
 - (c) To your knowledge has patient ever had the same or a similar condition? Yes ___ No ___
If "Yes" state when and describe: _____

2. Present Condition

(a) Is surgery: Required? Yes ___ No ___ Elective? Yes ___ No ___

If surgery is required, when was this patient informed by the attending physician?

Month _____ Day _____ Year _____

(b) Is patient? (Check One)

Ambulatory _____ House Confined _____ Bed Confined _____ Hospitalized _____

(c) Give a brief narrative of the nature and extent of the illness/injury: _____

3. Diagnosis: _____

4. Treatment for this illness/injury

(a) Date of first visit? Month _____ Day _____ Year _____

(b) Frequency of visits? Weekly ___ Monthly ___ Other _____

(c) When did you last examine the patient? Month _____ Day _____ Year _____

(d) Give a brief description of the treatment: _____

5. Prognosis

(a) If there are no further complications, what is the minimum recovery time to return to work? Approximate return date: _____

(b) What is the maximum recovery time to return to work? Approximate return date: _____

(c) Would there be the possibility of this patient returning to work on a part-time basis with job duties altered within reason to better fit his/her needs? Yes ___ No ___

(if so, how soon) Approximate return date: _____

Please explain limitations: _____

Please Feel Free to Attach Any Additional Documentation

Clinic Name

Signature of Attending Physician

Address

Date

Telephone