CITY OF CABOT
Catastrophic Leave Bank Program
APPLICATION for BENEFITS

Please type or print legibly Case# _____

Instructions	***NOTE***
Complete this form to apply for Catastrophic Leave. Attach all appropriate documentation of the medical emergency. Include the Physician's Certification for Catastrophic Leave. Present forms to your supervisor.	**The award of Catastrophic Leave is dependent upon its availability within the Catastrophic Leave Bank. The program does not create any expectation or promise of continued employment.**
Part 1 – Application and Certification *(To be completed by applicant employee or designee on his/her behalf).*	
Patient Name (*Last, First, Middle Initial)*	Relationship to Employee

If applicant has any qualifying family member(s) employed by the City, list their name(s) in the following sections

Name of family member	Department of family member	Social Security Number of family member

Applicant's Name (Last, First, Middle Initial)	Applicant's Social Security Number
Applicant's Position Title	Applicant's Hourly Rate of Pay

Department	Work Phone Number	Home Phone	Birthday: Year/Month/Day

Retirement and Social Security/Social Security Disability Benefits

☐ Yes ☐ No I am eligible for Retirement or Social Security benefits.
☐ Yes ☐ No I have applied for Retirement. If yes, date applied:
☐ Yes ☐ No I have applied for Social Security/Social Security Disability. If yes, date applied:

Applicant Certification: *(Check all appropriate sections)* ***I certify that:***

☐ 1. I have been affected by a medical emergency described on the attached Physician's Certification.
☐ 2. I have, or will have, exhausted all Leave and Compensatory Time as of the date indicated.
☐ 3. I expect to be absent from work without paid leave because of this medical emergency.
☐ 4. I had at least 60 hours of combined sick and annual leave at the onset of this illness/injury.
☐ 5. I have made application and am receiving Workers' Compensation Benefits in connection with this work-related condition.
☐ 6. I have made application but am not receiving Workers' Compensation Benefits in connection with this work-related condition.
☐ 7. I agree that any leave that I accrue while on Catastrophic Leave will be returned to the Catastrophic Leave Bank.
☐ 8. I understand that alleged abuse of the Catastrophic Leave Bank program shall be investigated, and, on a finding of wrong-doing, I shall repay all of the leave hours drawn from the program and shall be subject to such other disciplinary action as determined by the City.

Signature of Employee Receiving Catastrophic Leave or His/Her Designee	If Designee, state your relationship to Recipient	Date

Part II – Supervisory Verification *(To be completed by Applicant's Supervisor.)*

Disciplinary Action for Leave Abuse During past 2 years? ☐ Yes ☐ No	Explain why this employee's leave has been exhausted. **Be specific:**

Could this job be restructured temporarily to allow employee to return to work at an earlier date? ☐ Yes ☐ No **If Yes, attach revised job duties.**

Signature of Supervisor	Position Title	Phone Number	Date

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Employee/Applicant Name *(Last, First, Middle Initial)*	Social Security Number

Part III – Personnel/Payroll Verification (*To be completed by Human Resources.)*

Full-Time ☐ Yes ☐ No	Latest Hire Date	Date Employee Would Go on LWOP	Case Number

Date Leave Exhausted – Attach Leave Calendar(s) *(Includes Annual, Sick, Holiday and Comp- verified by HR)*	**Amount of Catastrophic Leave Requested**	**Duration Dates of Catastrophic Leave Request**	
Date / Time ☐ AM ☐ PM	Last Day Worked	Total Hours Requested *In one (1) hour increments*	Beginning Date / Projected Ending Date

HR Representative Name *(Print)*	HR Representative Signature	Phone Number	Date

WORKERS' COMPENSATION STATUS

Applied Date ☐ Yes ☐ No	Approved? Date ☐ Yes ☐ No	Pending? ☐ Yes ☐ No	Denied? Date ☐ Yes ☐ No

Amount of Workers' Compensation Weekly Benefits	Hourly Rate on Date of Accident	Hours of Catastrophic Leave Requested Weekly
Date Workers' Compensation Commenced	**Expected Duration**	**Date**

Part IV – Catastrophic Leave Committee Review and Recommendation

Date Received	Date Reviewed	**Dates of Duration of Approved Catastrophic Leave**	
		Beginning Date	**Projected Ending Date**

APPLICATION APPROVED ☐ Yes* ☐ No	Total Hours Awarded	Total Dollar Value of Leave Received	***INSTRUCTIONS*** *After review, recommendation and signature of Committee Chairperson, forward to Human Resources for processing.*
Signature of CLB Committee Chairperson/Designee		Date	

FINAL ACTION ☐ Approved ☐ Denied ☐ Concurred

Return originals to:
Human Resources

Part VI – Completed by CLB Record Keeper

Signature of CLB Record Keeper	Date

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PHYSICIAN'S CERTIFICATION

Employee Name

(Print or type) Last First Middle

Address

Street City/State Zip

Patient Name

(Print or type) Last First Middle Relationship to Employee

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release information acquired in the course of my examination or treatment to my employer's Catastrophic Leave Bank Program Committee for eligibility determination purposes for short-term disability benefits. I understand that this authorization to disclose information will expire thirty (30) days after the date of my signature or upon receipt by the physician of my written revocation, whichever comes first.

(Date) Employee's Signature (or Legal Representative)

(Date) Patient's Signature or Legal Representative (If Different than Employee)

THE EMPLOYEE AND/OR PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM AT HIS OR HER OWN EXPENSE
ALL INFORMATION LISTED ON THIS FORM WILL BE KEPT CONFIDENTIAL AND IS NOT TO BE RELEASED BY THE EMPLOYER WITHOUT WRITTEN CONSENT OF THE EMPLOYEE

(To be completed by the Patient's Physician)
Please Print or Type

THE FOLLOWING QUESTIONS APPLY ONLY TO THE CONDITIONS RELATED TO THE PATIENT'S APPLICATION FOR SHORT-TERM DISABILITY BENEFITS FROM THE CITY OF CABOT CATASTROPHIC LEAVE BANK PROGRAM

1. **HISTORY**

(a) When did patient first seek treatment for this illness/injury? Mo. _____ Day _____ Year _____

(b) Could this illness/injury be work related? Yes ☐ No ☐

(c) To your knowledge has patient ever had the same or similar condition? Yes ☐ No ☐
If "Yes," state when and describe:

2. **PRESENT CONDITION:**

(a) Is surgery: Required? ☐ Elective? ☐ Date of Surgery: _____

When was the patient informed by the attending physician? Mo. _____ Day _____ Year _____

(b) Is patient? (Check one) ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized

3. **DIAGNOSIS:** Give a brief narrative of the nature and extent of the present illness/injury which is creating the need for short-term disability provided by the City of Cabot Catastrophic Leave Bank Program:

4. **CONTINUING REQUIRED TREATMENT FOR THIS ILLNESS/INJURY**

(a) Projected Date of first office visit/treatment Mo. _____ Day _____ Year _____

(b) Frequency of visits/treatments Weekly ☐ Monthly ☐ Other _____

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

(d) Give a brief description of the continuing treatments required by this illness/injury:

5. **PROGNOSIS AND ANTICIPATED TIME DURATION THAT EMPLOYEE WILL BE UNABLE TO WORK DUE TO THE HEALTH CONDITION OF THE EMPLOYEE OR REQUIRED DIRECT CARE OF A FAMILY MEMBER**

(a) If there are no further complications, what is the minimum recovery time of the patient before the employee may return to work?
Approximate Return Date: _____

(b) What is the maximum recovery time of the patient before the employee may return to work?
Approximate Return Date: _____

(c) Is there a possibility of working an intermittent or reduced schedule or returning to work on a part-time basis with job duties altered, within reason, to better fit his/her needs?
Yes ☐ No ☐ If yes, Approximate Return Date: _____
Please explain any limitations:

_____

_____ _____
Clinic Name Signature of Attending Physician

_____
Address

_____ _____
Telephone Date