Department of Shared Administrative Services
Office of Personnel Management
Catastrophic Leave Application for Medical Emergency

OPM Case # _____

Instructions: Please complete this form to apply for catastrophic leave for a medical emergency due to illness/injury. Type or print legibly and attach all required documentation. Provide the completed application and applicable requirement to your supervisor.
Note: The award of catastrophic leave for medical emergency is based on the availability of donated leave within the OPM Catastrophic Leave Bank and the employee's eligibility for and compliance with law, policy and procedure. Authorized by A.C.A. §§ 21-4-203 and 21-4-214 and SAS-OPM Policy 47.

Part I - Application and Certification: (To be completed by employee or designee.)

Department Name _____ Business Area _____

Employee Name _____ Personnel Number _____

Work Phone _____ Home/Cell Phone _____ Email

Home Address _____ City/State/Zip _____

Name of Patient _____ Relationship to Patient _____ Patient's date of birth _____

I certify (Check the appropriate response for each statement.)

Yes ☐	No ☐	1. I am requesting catastrophic leave for a medical emergency as stated on the Physician's Certification.
Yes ☐	No ☐	2. I have/will have exhausted all paid accrued leave before using approved catastrophic leave.
Yes ☐	No ☐	3. I expect to be absent from work without paid leave due to the medical emergency.
Yes ☐	No ☐	4. I had at least 80 hours of combined sick and annual leave at the onset of the medical emergency OR I have attached the required documentation to request an extraordinary circumstance waiver.
Yes ☐	No ☐	5. I am eligible for retirement or social security disability benefits.
Yes ☐	No ☐	6. I have applied for retirement benefits. Date of application:
Yes ☐	No ☐	7. I have applied for social security/social security disability benefits. Date of application:
Yes ☐	No ☐	8. I am receiving social security/social security disability benefits. Date benefits began:

I understand and agree with the following:

- I have been employed with state government for at least one (1) year in a regular, full-time position.
- I will not accrue annual or sick leave while receiving catastrophic leave for the medical emergency during a period of 10 or more days in a month.
- If, during the period the employee is in a catastrophic leave status, any birthday or holiday leave is accrued, it will be removed and reflected as catastrophic leave.
- Any unused catastrophic leave for the medical emergency stated above shall be returned to the OPM Catastrophic Leave Bank. I will forfeit the catastrophic leave benefits if I terminate my employment or my employment is terminated.
- I will comply with the provisions of law, policy and procedure; if verified abuse, misrepresentation or fraud is found, I shall repay all of the leave hours awarded me from the OPM Catastrophic Leave Bank and be subject to disciplinary action up to and including termination.
- I will have my approved catastrophic leave due to illness/injury run concurrently with the Family and Medical Leave Act (FMLA) provisions, if eligible.
  The recommendations of the OPM Catastrophic Leave Committee or the State Personnel Administrator are not subject to grievance, arbitration or litigation.
- I consent to the encrypted electronic distribution of this document within and outside the agency for the purpose of completion, consideration and determination by my agency, TSS-OPM and the Catastrophic Leave Committee.

_____ _____

Employee's/Designee's Signature | If Designee, State Relationship | Date

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Employee's Name _____ Personnel Number _____

Part II - Supervisory Verification: (To be completed by employee's supervisor.)

From the date of this application, the employee has ☐ has not ☐ received a documented disciplinary action for leave abuse during the last one (1) year period.

Agency Supervisor's Name/Signature	Position Title	Work Phone	Date
_____	_____	_____	_____

Part III - Human Resources Verification: (To be completed by the agency human resources officer or designee.)

Position Title _____ Class Code _____ Pay Grade _____ Position # _____

Regular Position ☐ Yes ☐ No Hourly Rate of Pay _____ Career Service Date _____

Latest Hire Date _____ Last Day Worked _____ % of working time / # weekly work hours _____ / _____

Date employee will begin Leave Without Pay (LWOP) _____ Total catastrophic leave hours requested _____

Beginning Date of Approved Catastrophic Leave _____ Expected ending date of Approved Catastrophic Leave _____

Will the Catastrophic Leave be used intermittently: ☐ Yes ☐ No

Catastrophic Leave for Illness/Injury Benefits: ☐ Yes ☐ No Applicant applied for catastrophic leave for illness/injury during the past one (1) year period

If yes, how many hours were awarded/used by the applicant? _____ / _____

Workers' Compensation Benefits: ☐ Yes ☐ No Applicant applied for/received Workers' Compensation during the past one (1) year period.

If yes, what is the status of the application? ☐ Applied ☐ Pending ☐ Approved ☐ Denied

Date Worker's Comp began _____ Expected Duration _____

Amount of workers' comp weekly benefits _____ Hourly rate of pay on date of accident? _____

In conjunction with workers' comp benefits, how many hours of catastrophic leave for the medical emergency are needed weekly? _____

FMLA: Has the applicant applied for family and medical leave? ☐ Yes ☐ No Will the approved catastrophic leave run concurrently with FMLA leave? ☐ Yes ☐ No

If no, explain: _____

Name and Signature of HR Official or Designee	Position Title	Work Phone	Date
_____	_____	_____	_____

Part IV - Department Secretary or Designee Verification:

I certify the employee's application for catastrophic leave due to a medical emergency is appropriate and the information and supporting documentation provided by the agency is complete and correct.

Signature of Agency Director or Designee	If Designee, State Title	Date
_____	_____	_____