



**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

