San Diego Unified
SCHOOL DISTRICT

Catastrophic Leave Bank

REQUEST FOR WITHDRAWAL OF SICK LEAVE DAYS FROM THE CATASTROPHIC LEAVE BANK

Please **print** the following information:

Last Name:_____First Name:_____M.I.____

EMPL ID#:_____ Job Title:_____

Contact Information:_____ Work Location:_____

☐ Check here if partial contract, part-time employee, job-share, or reduced workload status.

Pursuant to the applicable Collective Negotiations Contract or Memorandum of Understanding, I hereby request that _____ (specify number) full-salary sick leave days be credited to my account. An initial credit of twenty days may be requested, followed by a request for twenty additional days (maximum of forty days).

☐ **This is my initial request.**
☐ **I have already received an initial credit. This is an additional request for up to 20 additional days.**

This is to acknowledge that this completed application must be accompanied by written verification, prepared and signed by a licensed physician of the State of California, certifying that I am suffering from a catastrophic illness or injury as defined in the applicable Collective Negotiations Contract or Memorandum of Understanding using the appropriate district form and shall state the nature of the illness or injury. I understand that any unused full-salary sick days will be returned to the Catastrophic Leave Bank. I have read the applicable contract language and acknowledge that all provisions governing the Catastrophic Leave Bank apply to this request.

Signature_____Date_____

RETURN TO:

San Diego Unified School District
Human Resource Services Division
4100 Normal St., Room 1241, San Diego, CA 92103

(619) 725-8172
Fax: (619) 296-7522

FOR DISTRICT USE ONLY: Date Received_____Date Logged_____Number of Hours_____

Approved by:_____Date:_____

SAN DIEGO UNIFIED SCHOOL DISTRICT
CATASTROPHIC LEAVE BANK
PHYSICIAN'S STATEMENT OF CATASTROPHIC ILLNESS OR INJURY
PLEASE PRINT

INSTRUCTIONS TO EMPLOYEE: Employee is to obtain physicians statement and signature, then submit this form along with the request of withdrawal from the Catastrophic Leave Bank to:

San Diego Unified School District
Human Resource Services Division
4100 Normal Street, Room 1241
San Diego, CA 92103

or fax: 619 296-7522

Employee Name:_____ EMPL ID:_____
Phone Number:_____ DOB:_____

INSTRUCTIONS TO PHYSICIAN: In addition to sick and vacation leave benefits, San Diego Unified School District also provides a peer-funded catastrophic leave bank for employees who are personally suffering from illnesses that are catastrophic in nature. We define catastrophic to mean a severe, incapacitating illness or injury which is expected to continue for a period of time which prevents an employee from performing his/her duties.

PHYSICIAN'S STATEMENT – The above named employee is under my professional care. Describe how the employee is suffering a catastrophic illness or injury and is completely unable to work (Please specify nature of illness or injury):

_____
_____
_____
_____
_____

Is the employee is unable to work in their usual and customary capacity but is able to work with modifications, restrictions and/or limitations? (Please clearly specify):

_____
_____
_____
_____
_____

This employee is anticipated to return to regular duty on:_____
(Date)

_____ _____ _____
Physicians Signature California License Number Date

_____ _____
Physicians Printed Name Physicians Phone Number