

Request for Catastrophic Leave Donation Program

Employee Name: _____ Request for Self Care for Eligible Family Member

Initial Request to participate in the Catastrophic Leave Donation Program (CLDP)

Initial CLDP Eligibility Period (up to 3 months): _____

Appropriate Administrator/Dean's Recommendation: The above-named employee has requested participation in this program. This program will supplement any disability benefits to bring them to full pay. All available leave credits for this employee must be exhausted before donation(s) may be used.

Recommend Not Recommended: _____

Name of Appropriate Administrator/Dean Signature Date

Approval for INITIAL Participation in the Catastrophic Leave Donation Program

Approved Denied--Reason: _____

Signature of Human Resources Manager - Benefits Date

Human Resources Use Only: Copy to Payroll Services _____ Employee: _____ E-mail to Union: _____

Request to EXTEND Participation in the Catastrophic Leave Donation Program (CLDP)

Request to EXTEND CLDP Eligibility Period (up to 3 months): _____

A written request for an additional three (3) months of participation in this program was received by Human Resources from the above-named employee on _____.

Approval to EXTEND Participation in the Catastrophic Leave Donation Program

Approved Denied--Reason: _____

Signature of Human Resources Manager - Benefits Date

Human Resources Use Only: Copy to Payroll Services _____ Employee: _____ E-mail to Union: _____