

**Request to Participate in the Catastrophic Leave Donation Program (CLDP)**

**Employee Name:** \_\_\_\_\_ **Bargaining Unit:** \_\_\_\_\_ **Fresno State ID:** \_\_\_\_\_

**Requirements:**

1. Must be on an approved Medical Leave. Contact Human Resources to discuss the leave process.
2. All eligible leave credits must be exhausted.
3. If the request is for the employee, the employee must be fully incapacitated to receive leave donations.\*
4. If the request to participate is to care for an eligible family member with a catastrophic illness or injury under the CSU FML, only vacation donations can be solicited to care for an eligible family member.\*\*

*\*If eligible for Non-Industrial Disability (NDI), the employee must apply for the NDI program to become eligible for the CLDP.  
\*\*Academic Year faculty who only earn sick leave are eligible to donate sick leave to employees who are requesting only vacation donations.*

<input type="checkbox"/> <b>Leave to Care for Eligible Family Member</b> <input type="checkbox"/> <b>Employee on Medical Leave</b>	<input type="checkbox"/> <b>Full Leave</b> <input type="checkbox"/> <b>Intermittent Leave</b>
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- Eligible for NDI program (CalPERS Member)  
 Not Eligible for NDI (Option discussed by Leave Coordinator)

**Initial CLDP Eligibility Period (up to 3 months):** \_\_\_\_\_

By signing below, I am requesting participation in the Catastrophic Leave Donation Program. I understand that the donations will either supplement my approved NDI payments or provide pay during my eligible unpaid absences for myself or eligible family member. My Union representative will be notified to solicit donations on my behalf, with the exception of MPP/Confidential.

**During my approved leave, I also wish to have HR solicit donations campus-wide.**

\_\_\_\_\_  
Employee Signature Date

★ *If the employee is unable to sign, an employee's eligible family member can request participation in the CLDP.* ★

**Extend CLDP Eligibility Period (up to 3 months):** \_\_\_\_\_

**Notification to Appropriate Administrator/Dean**

This document is to inform you that the above-named employee has requested participation in the CLDP. This program will supplement any disability benefits or cover eligible unpaid absences to bring them to full pay. If a payment issues for catastrophic donations, the payment is considered regular pay and the employee will appear on the departments Payroll Certification (Cert).

\_\_\_\_\_  
Name of Appropriate Administrator/Dean

**Human Resources Use Only**

<b>Initial Request</b>	<input type="checkbox"/> Approved <input type="checkbox"/> Denied: _____			
		_____ Signature (HR Manager – Benefits)	_____ Date	
<b>Extended Request</b>	<input type="checkbox"/> Approved <input type="checkbox"/> Denied: _____			
		_____ Signature (HR Manager – Benefits)	_____ Date	

**Copy to Payroll:** \_\_\_\_\_ **Copy to EE:** \_\_\_\_\_ **Copy to Admin:** \_\_\_\_\_ **Email to Union:** \_\_\_\_\_