

**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 4100 Normal St., Room 1241, San Diego, CA 92103
Attn: Gloria Rangel

(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 SDUSD, Human Resource Services Division, 4100 Normal Street, Room 1241, San Diego, CA 92103 Attention: Gloria Rangel. 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