



City of Belfast Catastrophic Leave Application

(Please review guidelines and procedures outlined on the back of this application form)

Employee Name: _____ **Employee ID#:** _____

Please Print

Department: _____ **Job Title:** _____

Option 1: I am requesting consideration of donated days following certification of Catastrophic Leave.

Please include:

1. A letter of explanation for your need.
2. A physician's letter of verification.
 - o A "catastrophic illness" or injury means a severe condition or combination of conditions affecting the physical health of the employee or a member of the employee's immediate family that requires the services of a licensed practitioner for a prolonged period and that forces the employee to exhaust all leave time earned by that employee and to lose compensation.

Such conditions typically require prolonged hospitalization or recovery or are expected to result in disability or death. Conditions related to pregnancy or childbirth shall be considered catastrophic if they meet the requirements of this paragraph due to medical complications.

3. To care for:
 - o An immediate family member (list relationship: _____)
 - o For my own serious health condition as defined above.

Employee Signature: _____ **Date:** _____

Human Resources Use Only:

Approved: _____

Not Approved: _____

Human Resource Administrator: _____ **Date:** _____

Day(s) credited as requested above: _____

City Manager: _____ **Date:** _____