Nevada System of Higher Education
REQUEST TO RECEIVE CATASTROPHIC (CAT) LEAVE

Section 1 -To be completed by the employee or designated representative *(please print or type)*

Name: _____ Employee ID# _____

Job Title: _____ Department: _____

Campus: ◯CSN ◯DRI ◯GBC ◯NSC ◯ System Administration ◯TMCC ◯WNC ◯UNLV ◯UNR

I am requesting catastrophic leave donations for (check one):

◯ My own medical condition requiring a "lengthy convalescence" *(per NAC 284.575)*

◯ My own medical condition which is "life threatening" *(per NAC 284.575)*

◯ A serious illness or accident which is "life threatening" or which will require a "lengthy convalescence" in my immediate family *(per NRS 284.362(2), NAC 284.5235, and NAC 284.558)*

◯ The death of an immediate family member *(per NRS 284.362(3) and NAC 284.5235 and NAC 284.558)*

If the request for catastrophic leave is due to a catastrophe in your immediate family, please indicate the name and your relationship to the family member.

Name_____ Relationship_____

I will need to use CAT leave beginning _____ and ending on _____for a total of _____ hours.

I have applied for Family Medical Leave (FMLA): ◯Yes ◯No

I authorize release of my name to the campus leave administrator to solicit CAT leave donations on my behalf. Solicitation may include but not limited to campus email, website and organization announcements. ◯Yes ◯No

Employee's Signature: _____ Date: _____

Submit Physician's Certification for Catastrophic Leave Request (*Form PAY-23C*) via Workday

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The approval or denial of the request is at the discretion of the appointing authority, who has the prerogative to ***not*** approve a request based upon the availability of funds on grant and soft money accounts or the employee's past leave history in accordance with NAC 284.576. Please review CAT leave policy for further information (available from your institution's absence partner).

An employee "aggrieved" by any decision of an appointing authority may appeal the decision by filing a written notice of appeal **(*Form PAY-23B*)** with the Committee on Catastrophic Leave within 10 days after the date of the decision.

Section 2 – To be completed by Department Absence Analyst, Supervisor and Appointing Authority

Department Absence Analyst: date employee exhausts all Time Off Accrued _____ FMLA status _____ Exhausted Approved Not eligible

Print Name: _____Signature_____Date_____

Supervisor Name: _____ Signature: _____ Date_____

Appointing Authority: leave request recommended for approval ☐ Yes ☐ No

Appointing Authority Name: _____Signature: _____ Date: _____

RETURN A COMPLETED FORM TO YOUR INSTITUTION ABSENCE PARTNER

Once your Absence Partner obtains the information from the department and employee's physician, the employee will be notified whether leave will be designated as Catastropic Leave. If you have any questions, please do not hesitate to contact your Absence Partner

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