Catastrophic Leave Bank Withdrawal Application

Name_____

Address _____

_____

Phone _____

School_____

Circumstances (provide pertinent details)

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_____

_____

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(ATTACH MEDICAL VERIFICATION)

Number of days_____

Dates requested _____

Physician/phone number

_____

_____

I have used all of my available sick leave. I have read and understand all the rules regarding the administration of Article 23.3 - Catastrophic Leave Bank. I hereby certify that the statements in this application are true and accurate to the best of my knowledge. I understand a false statement may result in my application to withdraw days from the Catastrophic Leave Bank to be disqualified.

Signature _____

Date_____