# City of Gardena

## *Catastrophic Leave Requested*

TO: Department Head Date: _____

I hereby request catastrophic leave from:

Catastrophic Leave Bank: _____ *(Department head to submit to Personnel Officer for approval of Health Benefits Committee and City Manager)*

Employee Leave Donations: _____

I have exhausted all my accrued leave as of _____ and anticipate being on leave for an additional _____ days (a maximum of thirty (30) workdays may be requested at a time) due to:

| | | Name of Person | Relationship to Employee |
|---|---|---|---|
| Emergency | _____ | _____ | _____ |
| Catastrophic Illness | _____ | _____ | _____ |
| Maternity Leave | _____ | _____ | _____ |
| Elective Surgery | _____ | _____ | _____ |
| Other *specify:* | _____ | _____ | _____ |

Attached is a medical verification from his/her physician or medical provider as requested.

Comments: _____

I have read and understand the requirements of the Catastrophic Leave and Leave Donations Programs and agree to adhere to the requirements within.

_____ _____
*Employee Signature* *Date*

***For Department Use Only***

Accrued leave balances exhausted: ☐ Yes ☐ No

Accrued leave balance if any: _____

Date last worked: _____

Verified by: _____ Date: _____

Department employee solicitation granted: ☐ Yes ☐ No Date: _____

Forwarded to Personnel Officer for City-wide solicitation: ☐ Yes ☐ No Date: _____

Forwarded to Personnel Officer for catastrophic leave bank: ☐ Yes ☐ No Date: _____

Reason if denied: _____

_____ _____
*Department Head Signature* *Date*

***For Personnel/Payroll Use Only***

Verified by: _____ Date: _____

Approved by: _____ Denied by: _____ Date: _____

Comments: _____

Original: Personnel Office Copies: Department and Employee