This is a fill-in form. Please click on the appropriate area to enter information. Tab between fields and PRINT when completed.

If using Adobe Acrobat Reader you CANNOT e-mail the form -- no data will be included.

State of Wisconsin
Office of State Employment Relations
Division of Compensation & Labor Relations

APPLICANT ELIGIBILITY VERIFICATION FOR CATASTROPHIC LEAVE

DATE:

TO: Agency/Campus Payroll Office

FROM:

SUBJECT: Catastrophic Leave Information Request

For Payroll Office Use Only:

Seniority Date: _____

FTE: _____

A Catastrophic Leave application has been received for

_____.
(Potential recipient)

The following individual has been contacted and consents to this application:

_____.
(Potential recipient or responsible family member)

Please provide the following information for the above named employee.

	Yes	No
Has completed first six months of an original probationary period?	☐	☐
Has used all sick leave and has no more than sixteen (16) hours of other available leave?[If "no," projected date for using leave as above is _____.]	☐	☐
Is on an approved LWOP? [If "no," projected start date for LWOP is _____.]	☐	☐
Anticipates unpaid leave of at least 160 hours duration (prorated for part-time employees)?	☐	☐
Is currently receiving other employer administered salary replacement benefits?	☐	☐
Is eligible for and will be receiving other employer administered salary replacement benefits? [If "yes," date employee will be eligible, if known: _____.]	☐	☐

Above information provided by: _____
(Name)

_____
(Work Address)

_____
(Work Telephone)

RETURN COMPLETED FORM TO: **(To union or agency/campus responsible for application review)**

CATASTROPHIC LEAVE APPLICATION APPROVAL/DENIAL: The request for Catastrophic Leave for the above named applicant has been approved / denied (circle one). Please process donations accordingly.

_____ _____
(Authorized Signature) (Date)

RETURN SIGNED APPROVED FORM TO RECIPIENT'S PAYROLL OFFICE FOR PROCESSING

Print Form Clear Form