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

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

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

SEE IMPORTANT INSTRUCTIONS ON NEXT PAGE!

APPLICATION FOR CATASTROPHIC LEAVE

Recipient's Name: _____

Classification: _____

Recipient is: Represented: By _____
Nonrepresented (Union) (Local or Chapter)

Home Address: _____

_____
(City) (State) (Zip)

Home Telephone: _____

Agency & Division: _____ Employing Unit: _____

Work Address: _____

_____
(City) (State) (Zip)

Work Telephone: _____

Anticipated Amount (Hours) of Catastrophic Leave Needed: _____

Anticipated Dates of Leave: From: _____ Through: _____

Continuous: _____ or Non-Continuous: _____

Other Salary Replacement Income/Benefits: No: ☐ Yes & what type: _____

Reason for Catastrophic Leave:

Application Made By: _____ _____
(Name) (Date)

Work Address (if State employee): _____

Work Telephone: _____ Home Telephone: _____ E-Mail Address: _____

RETURN COMPLETED FORM TO:

Print Form Clear Form

INSTRUCTIONS for FORM OSER-DCLR-12 (Application for Catastrophic Leave)

Determining Recipient Eligibility: In order to be an eligible recipient, an employee must satisfy *all* of the following conditions:

1. Be covered by Catastrophic Leave provisions under a collective bargaining agreement or s. ER 18.15, Wis. Adm. Code.
2. Have completed the first six months of an original probationary period in a permanent position or six months in a project position.
3. Be on an approved unpaid leave due to a catastrophic need of the employee or an immediate family member. The unpaid leave may be taken in noncontinuous increments.
4. Anticipate an approved unpaid leave of at least 160 hours duration, prorated for less than full-time employes.
5. Have provided medical certification of the catastrophic need if required by the union or agency.
6. Have used all available sick leave credits.
7. Have a leave balance of no more than 16 hours of combined accrued annual leave, including sabbatical/termination leave, and personal/legal holiday credits.
8. Must not be receiving other salary replacement income or benefits.
9. Must remain a state employee.

Recipient's Name: Name of the employee under consideration to receive Catastrophic Leave benefits.

Nonrepresented or Represented: Indicate whether the recipient is nonrepresented or represented by a collective bargaining unit. If represented, provide the name of the union, as well as the local union or chapter, as applicable.

Agency/Division/Employing Unit: Agency which employs the recipient, for example, Department of Health Services (DHS), Department of Corrections (DOC), or University of Wisconsin (UW). Division or Campus within the agency which employs the recipient, for example, Division of Long Term (DLTC) at DHS, Division of Adult Institutions (DAI) at DOC, or Madison Madison Campus at UW. Employing unit which employs the recipient for example, Central Wisconsin Center for the Developmentally Disabled (DHS/DLTC/CWC), Waupun Correctional Institution (DAI/DOC/WCI), or Housing (Madison Campus/UW).

Anticipated Dates of Leave: Indicate the date the leave is to begin and the date the leave is to end. Indicate whether the leave will be taken in one block of time (continuous) or in increments (non-continuous).

Other Salary Replacement Income/Benefits: Salary replacement income/benefits may include, but is not limited to: replacement income from other employment, income continuation insurance, worker's compensation, hazardous duty benefits under s. 230.36, Wis. Stats., unemployment compensation, social security, or private insurance.

Application Made By: Name of the individual completing application form, which may or may not be the potential recipient.

Return Completed Form To: For represented employees, the recipient's union and for nonrepresented employees, the recipient's agency personnel office.