

COUNTY OF GLENN CATASTROPHIC LEAVE SHARING PROGRAM



LEAVE REQUEST FORM

Confidential

Employee Name _____
Last First MI

Employee ID # _____ Job Title _____

Department _____ Work Phone # _____

Home Phone # _____ Last Day Worked _____

According to provisions of the Catastrophic Leave Sharing Program, I, _____,
hereby request donated vacation leave. My signature below certifies that:

1. A leave of absence in relation to a catastrophic illness or injury has been approved by my department;
2. I have exhausted or will soon exhaust all of my sick leave, vacation, and compensatory time accruals; and
3. I am not receiving Workers Compensation payments.

☐ GCPER 30 (Treating Physician's Statement) form attached.

I **do** authorize the use of my name in requesting donations of vacation leave from fellow County of Glenn employees.
You must sign this area to authorize the release of your name.

Employee Signature

Date

The Personnel Department will send a letter to all departments requesting donated leave on your behalf.

Catastrophic Illness/Injury is a non-industrial illness/injury of more than fourteen calendar days duration to an employee which presents an undue financial burden on the employee, or is an illness/injury of more than fourteen calendar days duration to an immediate family member of the employee which requires the employee to be present to care for the family member.

Submit original signed and completed form to: Glenn County Personnel Department

Questions regarding this program should be directed to the Personnel Department: 530-934-6451

Department Head Signature

Date

Personnel Department Signature

Date