TOWN OF HEMPSTEAD, N.Y. — NASSAU COUNTY — FOUNDED 1644

APPLICATION FOR CATASTROPHIC LEAVE

(*EXTENSION REQUEST*)

FORM CLPEXT; REVISED 09/2017

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: The purpose of the catastrophic leave program shall be to offer an employee who has exhausted his/her accumulated leave entitlements some level of assistance in the form of donated paid leave so that such an employee may attend to matters of necessity without suffering loss of pay. The program guidelines are dictated by Section 14-E of the Collective Bargaining Agreement and the Catastrophic Leave Policy.

This application is only to be used for an EXTENSION request for Catastrophic Leave.

Please complete Section I before giving this form to two (2) different health care providers for completion of Section II-A and II-B. Upon completion of Sections I, II-A and II-B please return the fully completed application to:

CSEA Local 880 c/o Catastrophic Leave Committee
1580 Merrick Road, Suite 212
Merrick, NY 11566

If you have any questions regarding this application or the Catastrophic Leave policy please contact CSEA Local 880 at 516-868-0880.

UPDATED EMPLOYEE INFORMATION:

1. NAME: ______________________ (LAST) ______________________ (FIRST) ______ (M.I.) DATE OF BIRTH: ____________ (MM/DD/YYYY)

ADDRESS: ______________________________ TELEPHONE NUMBER: ____________ ((XXX) XXX-XXXX)

CITY: ______________________________ STATE: ________ ZIP: ____________

ALTERNATE CONTACT NAME: ______________________ (LAST) ______________________ (FIRST) ______ (M.I.)

RELATIONSHIP: ______________ ALTERNATE CONTACT TELEPHONE NUMBER: ____________ ((XXX) XXX-XXXX)

2. PLEASE PROVIDE A BRIEF NARRATIVE AND THE DETAILS AS TO WHY YOU ARE REQUESTING AN EXTENSION OF YOUR CATASTROPHIC LEAVE? (i.e. This would be any relevant information to help the committee understand the continued catastrophic nature of your illness or injury including but not limited to: 1) Duration and type of treatment is indicated; 2) When you estimate to be able to return to work without restrictions; etc.

____

____

____

____

____

____

____

____

11. CERTIFICATION: I, ______________________________, hereby acknowledge that I have received and read a copy of the Catastrophic Leave policy. I also certify that all information and statements described herein are true and correct to the best of my knowledge. I understand that any false information or statements may disqualify me for catastrophic leave benefits as described in Section 14-E of the Collective Bargaining Agreement.

______________________________ Employee's Signature

______________ Date

SECTION II-A: For Completion by the HEALTH CARE PROVIDERS

INSTRUCTIONS to the HEALTH CARE PROVIDERS: Your patient has requested an extension of catastrophic leave under the collective bargaining agreement. Answer, fully and completely, all applicable parts. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Limit your responses to the condition for which the employee was originally granted catastrophic leave. If you need information regarding the patient's job specifications please contact Human Resources at 516-489-5000. DO NOT SEND COMPLETED FORM TO THE TOWN OF HEMPSTEAD; RETURN TO THE PATIENT.

PROVIDER'S PRINTED NAME: ______________________________

BUSINESS ADDRESS: ______________________________

TYPE OF PRACTICE/MEDICAL SPECIALTY: ______________________________

TELEPHONE: (_______)______________________ FAX:(________)______________________

1. LAST EXAMINATION DATE: ____________ (MM/DD/YYYY) NEXT EXAMINATION DATE: ____________ (MM/DD/YYYY)

2. HAVE THERE BEEN ANY CHANGES TO NATURE OF ILLNESS OR INJURY IN THE PAST 90 DAYS (Description should be in medical lay terminology): ______________________________

____

3. PROGNOSIS: ______________________________

4. RESPONSE TO TREATMENT: ______________________________

____

4. EMPLOYEE'S ESTIMATED RETURN TO WORK DATE WITH NO RESTRICTIONS: ____________

5. HEALTH CARE PROVIDER'S ORIGINAL SIGNATURE REQUIRED; STAMPED SIGNATURES NOT PERMITTED.

______________________	______________________	__________
Health Care Provider's Signature	National Provider Identifier (NPI)	Date

SECTION II-B: For Completion by the HEALTH CARE PROVIDERS

INSTRUCTIONS to the HEALTH CARE PROVIDERS: Your patient has requested an extension of catastrophic leave under the collective bargaining agreement. Answer, fully and completely, all applicable parts. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Limit your responses to the condition for which the employee was originally granted catastrophic leave. If you need information regarding the patient's job specifications please contact Human Resources at 516-489-5000. DO NOT SEND COMPLETED FORM TO THE TOWN OF HEMPSTEAD; RETURN TO THE PATIENT.

PROVIDER'S PRINTED NAME: ______________________________

BUSINESS ADDRESS: ______________________________

TYPE OF PRACTICE/MEDICAL SPECIALTY: ______________________________

TELEPHONE: (_______)______________________ FAX:(________)______________________

1. LAST EXAMINATION DATE: ____________ NEXT EXAMINATION DATE: ____________
MM/DD/YYYY *MM/DD/YYYY*

2. HAVE THERE BEEN ANY CHANGES TO NATURE OF ILLNESS OR INJURY IN THE PAST 90 DAYS (Description should be in medical lay terminology): ______________________________

____

3. PROGNOSIS: ______________________________

4. RESPONSE TO TREATMENT: ______________________________

____

4. EMPLOYEE'S ESTIMATED RETURN TO WORK DATE WITH NO RESTRICTIONS: ____________

5. HEALTH CARE PROVIDER'S ORIGINAL SIGNATURE REQUIRED; STAMPED SIGNATURES NOT PERMITTED.

______________________	______________________	__________
Health Care Provider's Signature	National Provider Identifier (NPI)	Date

SECTION III: For Completion by the CATASTROPHIC LEAVE COMMITTEE

INSTRUCTIONS to the CATASTROPHIC LEAVE COMMITTEE: This is a request for an extension of catastrophic leave. The purpose of the catastrophic leave program shall be to offer an employee who has exhausted his/her accumulated leave entitlements some level of assistance in the form of donated paid leave so that such an employee may attend to matters of necessity without suffering loss of pay. The program guidelines are dictated by Section 14-E of the Collective Bargaining Agreement and the Catastrophic Leave Policy. Please review Sections I, II-A and II-B of this employee's application and render a decision as to the whether or not the employee shall be entitled to an extension of Catastrophic Leave.

1. THE FULLY COMPLETED EXTENSION APPLICATION WAS RECEIVED BY CSEA LOCAL 880 ON ___________.
INSERT DATE

2. A MEETING WAS HELD BY THE CATASTROPHIC LEAVE COMMITTEE ON ______________________________
INSERT DATE AND TIME
AT ____.
NAME OF LOCATION, CITY AND STATE

3. IT WAS DETERMINED BY A VOTE OF THE CATASTROPHIC LEAVE COMMITTEE THAT THE EMPLOYEE:

__________ IS APPROVED FOR AN EXTENSTION OF CATASTROPHIC LEAVE UNTIL THE ESTIMATED RETURN TO WORK DATE OR SIXTY (60) WORKING DAYS, WHICHEVER IS SHORTER.

__________ IS DENIED FOR AN EXTENSION OF CATASTROPHIC LEAVE.

__________ IS REQUIRED TO PROVIDE MORE INFORMATION (DETAILS BELOW).

4. (IF DETAILS ARE REQUIRED) WHAT ARE THE NATURE OF THE DETAILS REQUIRED FROM THE EMPLOYEE?

____

____

5. ANY ADDITIONAL COMMENTS WITH REGARDS TO THIS APPLICATION? ______________________________

____

____

6. SIGNATURES OF THE CATASTROPHIC LEAVE COMMITTEE MEMBERS PRESENT:

1 . ______________________________ *CHAIRPERSON*	2 . ______________________________ *MEMBER*
3 . ______________________________ *MEMBER*	4. ______________________________ *MEMBER*
5 . ______________________________ *MEMBER*	6 . ______________________________ *MEMBER*