TRAVIS COUNTY HUMAN RESOURCES MANAGEMENT DEPARTMENT
CATASTROPHIC SICK LEAVE POOL
WITHDRAWAL FORM

EMPLOYEE INFORMATION

Date: ______

Employee ID: ______ Daytime Phone: ______

Employee Name: ______ Job Title: ______

Address: ______ Department: ______

State/Province: ______ Supervisor: ______

Zip/Postal Code: ______

WITHDRAWAL REQUEST INFORMATION

1. Date I expect to exhaust my paid leave (sick, vacation and compensatory leave) on: ______
2. Date I anticipate returning to work: ______
3. Number of Catastrophic Sick Leave hours requested: ______
4. This withdrawal request is for:

☐ My own catastrophic health condition

Is the catastrophic injury or illness work related? ☐ Yes ☐ No

☐ A catastrophic health condition of my immediate family member:

Family Member Name: ______ Relationship: ______

Is your family member a Travis County employee? ☐ Yes ☐ No

5. Are you currently on approved Family Medical Leave for the same or similar condition? ☐ Yes ☐ No

For this withdrawal to be complete, you are required to submit the Medical Certification form from you or your family member's health care provider that explains why, the type, and duration needed for you to care for your family member. Failure to submit a fully completed form may delay or cause your request to be denied.

I understand that this leave is granted on the condition that I comply and meet the guidelines as outlined by the Travis County Catastrophic Sick Leave Pool Policy and authorize the treating health care provider to release medical information to my employer.

Signature: ______ Date: ______

Administrator Use Only:

Catastrophic Sick Leave Hours are : ☐ Approved ☐ Denied ______

Number of Catastrophic Sick Leave hours approved: ______ Start Date: ______

☐ Entered/Notified timekeeper Signature: ______ Date: ______

(rev 08/2014)