

3430
CATASTROPHIC LEAVE PROGRAM
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1. General

The Catastrophic Leave Program is a voluntary program which allows employees to donate a portion of their annual leave to assist other employees within the same Organizational Unit who are experiencing an unusual or catastrophic illness and/or injury. For the purpose of this policy, an Organizational Unit is defined as all units which report to a vice president or the President. The Catastrophic Leave Program provides staff members an opportunity for continued pay status for up to six (6) months.

Employees suffering from a catastrophic illness or injury often find themselves without wage support because they have exhausted their annual and sick leave accruals and do not yet qualify for the University's Long Term Disability Insurance. Humanitarian interests in supporting co-workers are assisted and supported by this Program.

2. Eligibility

Any "regular" employee, as defined in "Employee Classification" Policy 3200, UBP, is eligible to participate in the Program after completing the University's probationary period. Within the same Organizational Unit, donations of annual leave by other employees may be used by any eligible staff employee affected by a catastrophic illness and/or injury who has insufficient leave to cover the required work absence. Use of catastrophic leave is subject to the same eligibility criteria listed in "Sick leave" Policy 3410, UBP, and the provisions of this policy.

2.1. Catastrophic Illness and/or Injury

A catastrophic illness and/or injury is defined as a medical or psychological event experienced by an employee, or a member of the employee's immediate family, which is likely to require an employee's absence from their job for a prolonged period of time. Immediate family is defined as mother; father; spouse; children (natural, legally adopted, or stepchildren); and siblings. This Program does not cover time off due to a job incurred injury covered by Workers Compensation Benefits.

3. Request for Assistance

To request assistance the employee or the employee's supervisor (acting on behalf of the employee at the employee's request) must submit a Catastrophic Leave Program Application (Exhibit A.) and the Physician/Psychologist Statement (Exhibit B.) to his or her department head. The Physician/Psychologist Statement must include a statement of the employee's inability to work, the diagnosis, and prognosis, including the anticipated date of return. In cases of personal emergency due to a family member's illness/injury, the Physician/Psychologist Statement must clarify that the illness requires attendant care which would result in the employee's inability to work.

3.1. Requests for assistance will be approved only after all annual and sick leave accruals have been exhausted. An employee must be facing at least five (5) or more days of unpaid leave, before an application may be submitted.

3.2. The department head reserves the right to request a second Physician/Psychologist Statement.

4. **Donated Leave**

Donated annual leave hours, up to amount indicated on the Physician/Psychologist Statement, will be transferred from the donating employee(s) to the recipient employee, as sick leave, on an hour for hour basis.

4.1. Any "regular" staff employee or twelve (12) month contracted faculty member may donate four (4) or more annual leave hours, but in no case more than forty (40) hours in one (1) calendar year. In addition, the employee donating annual leave must have a balance of eighty (80) hours remaining in their annual and/or sick leave banks after the donation.

4.2. Donations will only be made at the time of an authorized request for assistance. The donated annual leave hours will be reported through an approved Catastrophic Leave Program Annual Leave Donation form (Exhibit C.). This allows the Payroll Department to make the necessary adjustments to annual leave balances. Donations made will be transferred to the recipient employee, as sick leave. If the employee returns to work earlier than first expected, any significant number of unused hours may be transferred back, on a pro rata basis, to the employees who donated leave hours.

5. Administration of Program

The Catastrophic Leave Program will be administered by the department where the employee requesting assistance works. Technical and administrative support will be provided through the University Payroll Department and the University Department of Human Resources. The department where the employee requesting assistance works must complete the following steps.

5.1. The department head will review the application to determine if the applicant qualifies for assistance and the duration of that assistance. Applications that are denied must be reviewed by the applicable vice president, in consultation with the Department of Human Resources, within ten (10) working days of receipt.

5.2. The department head will inform other employees within the Organizational Unit of the employee's request for assistance. Unless the employee gives written permission, the only information released will be the employee's name and the number of hours needed.

Requests for donations of annual leave will first be presented to the department where the employee requesting leave works. If additional hours are needed, a request can be made by the dean or director to all of his or her departments. If additional hours are still needed, the request can be made to all employees in the Organizational Unit. In special circumstances and with the approval of the applicable vice presidents, donations of annual leave can be made from one Organizational Unit to another.

5.3. The department will send the approved application (Exhibit A.) and donation forms (Exhibit C.) to the Payroll Department. The application and donation forms should be sent to the Payroll Department within ten (10) working days of receipt of the application to allow the employee to be paid.

5.4. The employee receiving the donated leave will remain on "regular" status, utilizing sick leave for the period authorized. (Refer to "Sick Leave" Policy 3410, UBP.) Payroll deductions will continue to occur.

6. Confidentiality

All information received on Catastrophic Leave Program Applications, Physician/Psychologist Statements, Annual Leave Donation Forms, and any additional information is confidential.

7. Attachments

Exhibit A. Catastrophic Leave Program Application

Exhibit B. Catastrophic Leave Program Physician/Psychologist Statement

Exhibit C. Catastrophic Leave Program Annual Leave Donation Form

Exhibit A.

UNIVERSITY OF NEW MEXICO
CATASTROPHIC LEAVE PROGRAM APPLICATION

Return Application to: _____
Department Head

DATE: _____

NAME: _____ SS#: _____

HOME ADDRESS: _____ ZIP: _____

DEPARTMENT: _____ JOB TITLE: _____

TELEPHONE NO: WORK: _____ HOME: _____

NUMBER OF HOURS YOU ARE REQUESTING: _____

BEGINNING DATE: _____ ENDING DATE: _____

DATE OF HIRE: _____ LAST DAY WORKED: _____

PHYSICIAN/PSYCHOLOGIST NAME: _____
(ATTACH A CATASTROPHIC LEAVE PROGRAM-PHYSICIAN/PSYCHOLOGIST STATEMENT)

NATURE OF
ILLNESS: _____

IS THIS WORK RELATED? _____ IS SURGERY REQUIRED? _____

SURGICAL PROCEDURE REQUIRED: _____

DATE OF ONSET OF
CURRENT ILLNESS: _____ HAVE YOU HAD THIS ILLNESS
PREVIOUSLY? _____

HAVE YOU REQUESTED CATASTROPHIC LEAVE FOR THIS CONDITION PREVIOUSLY?

YES _____ NO _____ IF SO, WHEN? _____

APPLICANT'S SIGNATURE: _____

REQUEST APPROVED _____ REQUEST DENIED _____

ADMINISTRATOR'S SIGNATURE _____ DATE _____

Please provide ALL information requested. Incomplete applications will not be processed.

Exhibit B.

**UNIVERSITY OF NEW MEXICO
CATASTROPHIC LEAVE PROGRAM
PHYSICIAN/PSYCHOLOGIST STATEMENT**

PATIENT'S NAME: _____

PATIENT'S ADDRESS: _____

NAME OF WORK LOCATION: _____

I authorize _____ to release information to UNM's Catastrophic Leave Program and the Department of Human Resources/Employee Services Office.

PATIENT'S SIGNATURE: _____ DATE: _____

MEMO TO PHYSICIAN/PSYCHOLOGIST:

The employee requesting this statement is applying to UNM's Catastrophic Leave Program for PAID days to cover the absence due to illness. The Catastrophic Leave Program is available to UNM employees who have exhausted all accumulated leave and have an unusual or catastrophic illness. Employees who have a family member with an illness, which will require attendant care and result in the employee's inability to work, also qualify.

PLEASE provide the CLP/Organizational Unit all of the information requested. An incomplete statement may delay processing of the employee's application and may cause withholding from the next paycheck.

THANK YOU FOR YOUR COOPERATION!

Exhibit B. page 2

PLEASE TYPE OR PRINT YOUR ENTRIES

DATE OF ONSET OF CONDITION: _____

DIAGNOSIS AND NATURE OF
CONDITION: _____

PROGNOSIS: _____

Have you treated the patient previously for this condition? YES ___ NO ___

PLEASE provide detailed information on TREATMENT & PRESCRIBED MEDICATION for the period of the time being requested.

TREATMENT PLAN: _____

_____ IS PATIENT ABLE TO WORK? _____

DATE PATIENT CAN RETURN TO WORK? _____

RESTRICTIONS: _____

PHYSICIAN'S/PSYCHOLOGIST'S SIGNATURE: _____

DATE: _____ PRINT NAME: _____

Exhibit C.

**UNIVERSITY OF NEW MEXICO
CATASTROPHIC LEAVE PROGRAM
ANNUAL LEAVE DONATION FORM**

I would like to donate ANNUAL LEAVE to: _____
in the amount of:

- ☐ four (4) hours ☐ eight (8) hours
☐ twelve (12) hours ☐ other, indicate amount _____

The minimal amount of donation is - four (4) hours; the maximum amount allowable is - forty (40) hours. The employee donating the leave must have a balance of eighty (80) hours remaining in their annual and/or sick leave banks, after the donation.

I understand that the University Payroll Department will deduct the above specified hours of annual leave from my annual leave records. I affirm that this leave is given freely, without any promise of benefit or threat of reprisal if I fail to make this donation. I understand this donation is irrevocable.

SIGNATURE: _____ DATE: _____

FULL NAME: _____ SS#: _____
(Please print or type)

DEPARTMENT: _____

JOB TITLE: _____

- ☐ FACULTY
☐ MONTHLY/EXEMPT STAFF
 ☐ Regular Full-Time
 ☐ Regular Part-Time
☐ BI-WEEKLY/NON EXEMPT STAFF
 ☐ Regular Full-Time
 ☐ Regular Part-Time

TO BE COMPLETED BY THE DONOR'S DEPARTMENT

ANNUAL LEAVE BALANCE BEFORE DONATION _____

NUMBER OF HOURS DONATED _____

NEW ANNUAL LEAVE BALANCE _____

SICK LEAVE BALANCE _____

AUTHORIZED FOR PROCESSING: _____
Department Head

Return to the Department which made the request. Keep a copy for departmental files.