

ARKANSAS FORESTRY COMMISSION  
**Catastrophic Leave Bank Program**  
**Recipient Application Form**  
Authorized by A.C.A. 21-4-214 et. seq.

Please type or print legibly.

Case #: \_\_\_\_\_

**INSTRUCTIONS**

Complete this form to apply for Catastrophic Leave Time. Attach all appropriate documentation of the medical emergency. Include the Physician's Certification for Catastrophic Leave and the Catastrophic Leave Bank (CLB) Liability Agreement. Present forms to your supervisor.

**NOTE**

The award of Catastrophic Leave is dependent upon its availability within the Catastrophic Leave Bank. The program does not create any expectation or promise of continued employment.

**PART I – APPLICATION AND CERTIFICATION** (To be completed by applicant employee or designee on his/her behalf).

Patient Name (Last, First, Middle Initial) Relationship to Employee

**List qualifying family member(s) employed by the State:**

Name Agency Social Security Number

Name Agency Social Security Number

Employee Name (Last, First, Middle Initial) AASIS # & Position Number Social Security Number

Class Code of Position Position Title Grade Hourly Rate of Pay

AFC Unit Work Phone Number Home Phone Number Birthday: Year/Month/Day

**RETIREMENT AND SOCIAL SECURITY/SOCIAL SECURITY DISABILITY BENEFITS**

- Yes  No I am eligible for Retirement or Social Security benefits.  
 Yes  No I have applied for Retirement. If yes, date applied \_\_\_\_\_.  
 Yes  No I have applied for Social Security/Social Security Disability. If yes, date applied \_\_\_\_\_.

**Certification:** (If certifying on behalf of employee, modify as appropriate.) I certify that:

- I have been affected by a medical emergency described on the attached Physician's Certification.
- I have or will have exhausted all Leave and Compensatory Time as of the date indicated above.
- I expect to be absent from work without paid leave because of this medical emergency.
- I had at least 80 hours of combined sick and annual leave at the onset of this illness/injury.
- I have applied for and **am** receiving Workers' Compensation Benefits in connection with this work-related condition.
- I have applied but **am not** receiving Workers' Compensation Benefits in connection with this work-related condition.
- Any leave accrued while on Catastrophic Leave will be returned to the Catastrophic Leave Bank.

Signature of Employee Receiving Catastrophic Leave or His/Her Designee. **If Designee, state your relationship to Recipient.**

Date:

**PART II – SUPERVISORY VERIFICATION** (To be completed by Applicant's Supervisor.)

Disciplinary Action for Leave Abuse During past 2 years?  Yes  No  
Explain why this employee's leave has been exhausted. **Be Specific:**

Could this job be restructured temporarily to allow employee to return to work at an earlier date?  Yes  No  
**If yes, attach revised job duties.**

Signature of Supervisor Position Title Phone Number Date

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Employee Name (Last, First, Middle Initial) Social Security Number

**PART III – PERSONNEL/PAYROLL VERIFICATION** (To be completed by AFC Personnel Manager.)

Full-Time <input type="checkbox"/> Yes <input type="checkbox"/> No	Career Service Date	Latest Hire Date	Date Employee Would Go On LWOP	Case Number
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**Date Leave Exhausted:** – Attach Leave Calendar(s) – (Includes Annual, Sick, Holiday and Comp – verified by Timekeeper)

**Amount of Catastrophic Leave Requested:**

**Duration Dates of Catastrophic Leave Request:**

Date	Time A.M. P.M.	Last Day Worked
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Total Hours Requested In one (1) hour increments	Beginning Date	Projected Ending Date
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Timekeeper's Name (Print)	Timekeeper's Signature	Phone Number	Date
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**WORKERS' COMPENSATION STATUS**

Applied? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	Approved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	Pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	Denied? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date
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Amount of Workers' Compensation Weekly Benefits \_\_\_\_\_ Hourly Rate on Date of Accident \_\_\_\_\_

Hours of Catastrophic Leave Requested Weekly \_\_\_\_\_ Date Workers' Compensation Commenced \_\_\_\_\_

Expected Duration \_\_\_\_\_ Date \_\_\_\_\_

**PART IV – CATASTROPHIC LEAVE COMMITTEE REVIEW AND RECOMMENDATION**

Date Received	Date Reviewed	Dates of Duration of Approved Catastrophic Leave Beginning Date: <span style="float: right;">Projected Ending Date:</span>
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Application Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Hours Awarded	Total Dollar Value of Leave Received
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**INSTRUCTIONS:** After review, recommendation and signature of Committee Chairperson, forward to State Forester for final review and consideration of recommendation.

Signature of CLB Committee Chairperson/Designee Date

**PART V – DIRECTOR'S REVIEW AND ACTION**

**FINAL ACTION**     **Approved**     **Denied**     **Concurred**

Signature of State Forester Arkansas Forestry Commission    Date

**PART VI – COMPLETED BY CLB KEEPER**

Signature of CLB Record Keeper Date Entered