Department of Transformation and Shared Services - Office of Personnel Management

Catastrophic Leave Bank Program Application for Maternity Purposes

Print Form

Authorized by ACA §§ 21-4-203, 21-4-209, 21-4-214

OPM Case # _____

Instructions: Please complete this form to apply for catastrophic leave for maternity purposes. Type or print legibly. Note: the requirements by each maternity purpose below. Provide the completed application and applicable requirement to your supervisor.

NOTE: The award of catastrophic leave for maternity purposes is based on the availability of donated leave within the OPM Catastrophic Leave Bank and the employee's eligibility for and compliance with law, policy and procedure.

Part I - Application and Certification: (To be completed by employee or designee on the employee's behalf.)

Employee's Name (Last, First) _____ Personnel Number _____

Agency Number and Name _____ Work Phone _____

Home Address _____ Home/Cell Phone _____ Home e-mail address _____

Applicant Certification: (Check the appropriate box.)

I certify I am requesting catastrophic leave for maternity purposes due to:

☐ 1. The birth of my biological child. (Applicant must provide agency HR officer acceptable proof of actual date of birth.)

☐ 2. The placement of an adoptive child in my home. (Applicant must provide agency HR officer acceptable proof of placement date.)

I understand and agree with the following:

I have been employed with state government for at least one (1) year in a regular, full-time position.
I am not required to exhaust annual or sick leave before being granted catastrophic leave for the maternity purpose stated above.
I will not accrue annual or sick leave while receiving catastrophic leave for the maternity purpose stated above for the month the catastrophic leave begins.
If, during the period the employee is in a catastrophic leave status, any birthday or holiday leave is accrued, it will be removed and reflected as catastrophic leave.
I may be granted up to four (4) consecutive weeks of catastrophic leave with pay within the first twelve (12) weeks after the birth of my biological child or placement of an adoptive child in my home.
After the expiration of the four (4) weeks of catastrophic leave for either maternity purpose above, maternity leave shall be treated as any other leave for sickness or disability per ACA § 21-4-209.
I will forfeit the catastrophic leave benefits if I terminate my employment or my employment is terminated.
I will have my approved catastrophic leave for maternity purposes run concurrently with the Family and Medical Leave Act (FMLA) provisions, if eligible.
I will comply with the provisions of law, policy and procedure; if verified abuse, misrepresentation or fraud is found, I shall repay all of the leave hours awarded me from the OPM Catastrophic Leave Bank and be subject to disciplinary action up to and including termination.
I have not applied for and am not receiving social security disability benefits.
Any unused catastrophic leave for the maternity purpose stated above shall be returned to the OPM Catastrophic Leave Bank.
I consent to the encrypted electronic distribution of this document within and outside the agency for the purpose of completion, consideration and determination by my agency and DFA-OPM.

_____ _____ _____

Signature of Employee/Designee Requesting Catastrophic Leave for Maternity Purposes | If Designee, State Relationship | Date

Part II - Supervisory Verification: (To be completed by employee's supervisor.)

I am aware this employee is ☐ will be ☐ eligible to apply for catastrophic leave for maternity purposes from the date of this application.

_____ _____ _____ _____

Agency Supervisor's Name/Signature | Position Title | Work Phone | Date

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Employee's Name (Last, First) _____ Personnel Number _____

Part III - Human Resources Verification: (To be completed by the agency human resources officer or designee regarding the employee.)

Position Title _____ Class Code _____ Pay Grade _____ Position # _____

Full-time ☐ Yes ☐ No Hourly Rate of Pay _____ Career Service Date _____

Latest Hire Date _____ Last Day Worked _____ Date of Birth _____

Beginning date of approved catastrophic leave for maternity purposes _____ Expected ending date _____

Total hours requested _____ Proof of birth or placement has been provided: ☐ Yes ☐ No

Catastrophic Leave for Illness/Injury Benefits: ☐ Yes ☐ No Applicant applied for catastrophic leave for illness/injury during the past one (1) year period.

If yes, how many hours of catastrophic leave were awarded/used by the applicant? ____ / ____

Catastrophic Leave for Maternity Purposes: ☐ Yes ☐ No Applicant applied for catastrophic leave for maternity purposes during the past one (1) year period.

If yes, how many hours of catastrophic leave were awarded/used by the applicant? ____ / ____

Workers' Compensation Benefits: ☐ Yes ☐ No Applicant applied for/was receiving Workers' Compensation during the past one (1) year period.

If yes, what is the status of the application? ☐ Applied ☐ Pending ☐ Approved ☐ Denied

Date workers' comp began _____ Expected duration _____

Amount of workers' comp benefits _____ Hourly rate of pay on date of accident? _____

In conjunction with workers' comp benefits, how many hours of catastrophic leave for maternity purposes are needed weekly? _____

FMLA: Has the applicant applied for family and medical leave? ☐ Yes ☐ No Will the approved catastrophic leave run concurrently with FMLA leave? ☐ Yes ☐ No

If no, explain: _____

Agency Human Resources Officer's or Designee's Name/Signature	Position Title	Work Phone	Date

Part IV - Agency Director or Designee Verification: (To be completed by the agency director or designee.)

I certify the employee's application for catastrophic leave due to the designated maternity purpose is appropriate and the information provided by the agency is complete and correct.

Signature of Agency Director/Designee	If Designee, State Title	Date