



**CONTRA COSTA COUNTY  
CATASTROPHIC LEAVE APPLICATION (*CONFIDENTIAL*)**

The Catastrophic Leave Committee meets on the **third** Wednesday of every month. Please have your application into the Human Resources Department, Employee Benefits Services Unit by the Friday before the meeting. Fully complete the application (pg.1&2) for consideration. **Please be advised that receiving wages for any hours worked while on Catastrophic Leave will cease your eligibility for the program.**

**I, or a member of my immediate family, (definition sick leave policy) have sustained a catastrophic illness, injury or condition and request assistance from the Catastrophic Leave Bank.**

I am a: Full Time  Part time  (\_\_\_\_\_ hrs/wk) Permanent Intermittent  Employee

My last day at work was: \_\_\_\_\_

I have exhausted all paid time or will do so by approximately: \_\_\_\_\_

I have applied for a medical or family care leave of absence on: \_\_\_\_\_

I anticipate returning to work on: \_\_\_\_\_

I have applied for and am receiving benefits from the following: **(mark all that apply)**

		Amount	Period	Reason
State Disability (SDI)	<input type="checkbox"/>	\$ _____	_____	_____
County Long Term Disability (LTD)	<input type="checkbox"/>	\$ _____	_____	_____
Labor Coalition Union LTD Insurance	<input type="checkbox"/>	\$ _____	_____	_____
Social Security Disability Payments	<input type="checkbox"/>	\$ _____	_____	_____
Workers Compensation	<input type="checkbox"/>	\$ _____	_____	_____

I agree to notify the Committee immediately of any changes to my circumstances or condition which may affect my entitlement to Catastrophic Leave and to received funds from the above listed disability programs.

**I could perform light / limited duty or an alternate work assignment:** Yes  No   
(Please explain)

**I have been offered light / limited duty/ alternate work assignment by my department:** Yes  No   
(Please explain)



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**NOTE: THE COMMITTEE CONSIDERS ALL CATASTROPHIC LEAVE APPLICATIONS ANONYMOUSLY.**

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Please describe details of the illness, injury or condition which your applications is based on. Include why you feel this is a catastrophic situation. **MEDICAL VERIFICATION of the condition described below that includes a prognosis and projected return to work date must be attached.**

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Employee Name: \_\_\_\_\_ Employee #: \_\_\_\_\_

Address: \_\_\_\_\_ Department: \_\_\_\_\_

\_\_\_\_\_ Work Ph. # \_\_\_\_\_

\_\_\_\_\_ Home Ph. # \_\_\_\_\_

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

When complete, seal application in an envelope labeled **CONFIDENTIAL**. Mail or deliver to:

**Contra Costa County, Employee Benefits Service Unit  
Attn: Catastrophic Leave Committee Coordinator  
1025 Escobar Street, 2nd Floor  
Martinez, CA. 94553**

For questions or concerns, email [Benefits@hrd.cccounty.us](mailto:Benefits@hrd.cccounty.us) or contact (925) 655-2100.