City of Ripon
Catastrophic Leave Program Request Form

Employee Information

Employee Name: _____

Phone Number: _____

E-Mail address _____

Department: _____

Hours requested: _____

Last day worked: _____

Expected return to work date: _____

Acknowledgement

I am a regular full-time employee who has completed the probation period in accordance with the City of Ripon Merit System.

I am, or a family member* is, experiencing a catastrophic or serious illness, injury or other medical condition that is not work related which prevents me/them from being able to work for at least 7 days.**

I have exhausted all of my paid leave balances or will do so before returning to work.

I am not receiving Workers' Compensation or any other disability payments.

I have provided documentation of a medical diagnosis from a qualified health provider.

By signing below I acknowledge all of the above items:

Employee Signature: _____

Date:

Please allow one week for processing.

Approvals:

_____ _____

Payroll/HR Technician Date

_____ _____

City Administrator Date

*A family member for this program is defined as spouse, registered domestic partner, or another dependent as defined in the Internal Revenue Code (26 U.S.C. sec 152 as amended from time to time)

**A catastrophic or serious illness, injury or other medical condition, for this program, is defined as an acute or prolonged illness, injury, or other medical condition resulting in the employee's inability to work, either due to his/her own injury, illness or medical condition, or that of a family member, requiring that the employee take time off work to care for the seriously ill or injured family member.