**Catastrophic Leave Request Form**

*Submit original signed and completed form to the Office of Human Resources, B&O Building, Office 125, 1704 Market Street Wheeling, WV 26003, email to HR@wvncc.edu, or fax to 304.233.5837.*

Employee Full Name: Title:

Department: Last Day Worked:

I hereby request catastrophic leave for the period of: to .

My signature below certifies that:

1. I have/will have exhausted all of my sick leave, vacation, and compensatory time accruals; and
2. I am not receiving disability benefits or Workers Compensation payments.
3. I have provided/will provide the requested supporting medical verification documentation.
4. I am not receiving any other salary replacement benefit.

I understand that all information submitted will be reviewed, and that I will be notified of the decision. I also understand that I am not permitted to contact employees and ask for donations of leave on my behalf or ask any other employee to do so for me.

Employee Signature Date

*Submit original signed and completed form to the Office of Human Resources, B&O Building, Office 125, 1704 Market Street Wheeling, WV 26003, email to HR@wvncc.edu, or fax to 304.233.5837.*

*Questions regarding this program should be directed to the Director of Human Resources at rbrak@wvncc.edu.*