Request Form for Catastrophic Illness Leave

Name (Please Print)_____

Employee ID Number _____

Agency/Office Location _____

Date of Employment with the State of Nebraska_____

Numbers of Hours requested _____*(Attached medical verification must support number of hours requested)*

Reason for Request _____

_____

_____

(attached medical verification must support reason for absence)

Medical Verification supporting this request is attached

_____ _____

Signature **Date**

Human Resource Use Only:

____Eligible for Catastrophic Leave Donations Copy sent to Employee _____ (date)
Position Number _____

____Ineligible for Catastrophic Leave Donations

Reason: _____

_____

Verified by _____ Date _____
Human Resource Contact