



### CATASTROPHIC LEAVE RECIPIENT APPLICATION

The Catastrophic Leave Program (WV Code 18B-9-10) provides for the transfer of sick and annual leave credit(s) from eligible voluntary donor(s) for use by an approved employee (recipient) who has exhausted all leave and other paid time off due to a catastrophic illness/injury incurred by the employee or a primary family member.

Name (Last , First)

Department:

WVU Employee #

Supervisor:

Address:

Home Phone #

E-mail

**I am seeking catastrophic leave for an injury/illness for::**

*Last day actively working:*

*Date own leave will exhaust:*

*Myself*

*Immediate family member*

**If immediate family member, please provide their full name:**

**Relationship to you:**

*Brief description of reason needed for leave:*

No consideration will be made for participation in this program without receipt of the this application, the required [Medical Verification Form](#) and eligible donations sufficient for full pay within the affected pay period.

*I acknowledge that I am an active WVU employee and that all information provided on this form is truthful and accurate.*

*Signature (electronic signature accepted):*

*Date (mm/dd/yyyy):*

**PLEASE RETURN FORM TO:** WVU Division of Human Resources~ Medical Management Unit  
**MAIL:** PO Box 6640 Morgantown, WV 26506-6640  
**FAX:** (304) 293-2644  
**EMAIL:** medicalmanagement@mail.wvu.edu