



West Virginia State University Catastrophic Leave Recipient Application

Employee Name:	
Home Phone Number:	
Address:	
City/State/Zip:	
Department:	
Job Title:	
Supervisor:	
Work Phone:	
Last Day Actively Working:	
Date Leave Exhausted:	

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

Myself Family Member

If primary family member, name:

Relationship to employee:

The Catastrophic Leave Program (West Virginia Code 18B-9-10) provides for the transfer of eligible leave from voluntary donors for use by an approved employee who has exhausted all leave and other paid time off due to a catastrophic illness or injury.

Please provide a brief summary of the medical condition (attach additional pages if needed):

IMPORTANT: Before this application will be considered, the recipient must submit a completed Medical Leave Verification Form confirming diagnosis, prognosis, recommended treatment, and anticipated duration of the catastrophic illness/injury.

Employee Signature: _____ Date: _____