Human Resources

COMPASSIONATE TRANSFER OF LEAVE (CTL) REQUEST FORM

INFORMATION ABOUT EMPLOYEE

Submit the completed form to Human Resources, Leaves Administration at leaves@arizona.edu.

The employee's personal or department representative may complete the form if the employee is incapacitated.

Name: _____ Empl ID: _____
Last, First MI

Personal Phone: _____ Personal Email: _____

LEAVE INFORMATION

I am requesting a leave of absence:

Beginning: _____ Ending: _____ CTL Hours Expected: _____

EMPLOYEE ACKNOWLEDGEMENT

I request that I be allowed to receive compassionate transfer of leave. According to the Compassionate Transfer of Leave Policy, I understand that I must meet the following criteria. Please read through each statement and add a checkmark in the box to indicate your agreement/understanding.

☐ 1. I am on an approved leave of absence.
☐ 2. I have been employed at UA in a benefits-eligible position for at least 12 continuous months.
☐ 3. I was eligible to accrue vacation hours when my leave began.
☐ 4. I have exhausted all forms of paid time off (vacation, sick, compensatory time) before I can receive CTL.
☐ 5. I have submitted a doctor's statement confirming that I, or a member of my immediate household, have a catastrophic medical condition expected to last at least 45 days. Of my own condition, I cannot perform all duties of my job or any available light-duty work.
☐ 6. If I am enrolled in a short-term disability plan, I understand I must apply for this benefit and that CTL may supplement short-term disability payments up to, but not exceeding, my regular rate of pay.
☐ 7. CTL cannot exceed the anticipated period of short-term disability.
☐ 8. I am not eligible to receive long-term disability or workers' compensation benefits, and if I begin to receive this benefit, I will no longer be eligible to receive CTL.
☐ 9. This is not an on-the-job injury. (If on-the-job injury, contact Risk Management at 520-621-1790 to prevent subsidization of workers' comp benefits)

_____ _____
Employee Signature Date

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REDUCED / INTERMITTENT SCHEDULE

This field should be left blank if continuous leave is requested; otherwise, it must be filled out with the approval of the employee's supervisor.

Schedule Change Start: _____ Schedule Change End: _____

Reduced Schedule: _____

_____

Intermittent Schedule: _____

_____

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature (only needed for reduced/intermittent schedule) Date

HUMAN RESOURCES USE ONLY

Verified CTL Hours Available _____ Short-Term Disability Plan _____

_____ _____

HR Representative Name/Signature Date