Human Resources

COMPASSIONATE TRANSFER OF LEAVE (CTL) REQUEST FORM

INFORMATION ABOUT REQUESTING EMPLOYEE

Submit the completed and signed form to your department representative. (Form may be completed by the requesting employee's personal representative or department if the employee is incapacitated.) The department representative will sign and submit the original form to the Division of Human Resources.

Name: _____ _____ _____
Last First Middle

Employee ID: _____ _ **Leave Start Date:** _____

Expected Leave End Date (if known): _____ **No. of CTL Hours Expected (if known):** _____

I request that I be allowed to receive any compassionate transfer of leave. According to the Compassionate Transfer of Leave Policy, I understand that I must meet the following criteria. Initial on *each* line.

____1. I have been employed at UA for at least 12 continuous months.

____2. I was eligible to accrue vacation hours at the time my leave began.

____3. I have exhausted all forms of paid leave (vacation, sick leave, and compensatory time) prior to receiving CTL.

____4. I am not eligible to receive long-term disability or workers' compensation benefits. If I begin to receive such benefits, I will no longer be eligible to receive CTL.

____5. If I am enrolled in a short-term disability plan, I understand I must apply for benefits and that CTL may supplement short-term disability payments up to, but not to exceed, my regular rate of pay.

____6. CTL cannot exceed the anticipated period of disability.

____7. I have attached a doctor's statement confirming that I have a catastrophic medical condition, or I am a caregiver for a member of my immediate household with a catastrophic medical condition, expected to last at least 45 days. For my own condition, I am unable to perform all duties of my job or any available light duty work.

_____ _____
Employee Signature Date

PROCESSING INFORMATION (To be filled out by requesting employee's department representative)

Was this an on-the-job injury? No ☐ Yes ☐ (contact Risk Management to prevent subsidization of workers' comp benefits)

To the best of my knowledge, this employee has met eligibility requirements to receive contributions under the Compassionate Transfer of Leave Policy. (Arizona Board of Regents Policy#6-809; Classified Staff Policy 201.1; University Handbook for Appointed Personnel Policy 8.02.04)

The department is responsible for monitoring usage of CTL hours and ensuring that only eligible CTL hours are approved on the employee's timesheet. CTL hours must not be reported for time when the employee is at work.

Employee is eligible for CTL and has the following number of hours available: _____

_____ _____ _____
Department Representative Name Department Representative Signature Date

HUMAN RESOURCES USE ONLY

Verified CTL Hours available: _____ Short-term Disability Plan (if enrolled): _____

_____ _____ _____
Human Resources Representative Name Human Resources Representative Signature Date