



Request for Use of Catastrophic Leave Bank – Certificated

Article 11.14

Name: _____ Date: _____ Work site: _____

Days Hours # requested _____ Anticipated start date: _____

Reason for request. Provide sufficient information for the Committee to determine that the criteria for use of CLB has been met. Please attach Physician’s verification of medical condition.

The SSEA Executive Committee met on _____ and took the following action on your request.

Request approved for _____ days.

Request denied _____

SSEA President (or Designee) _____ Date _____