

**Fairfield-Suisun Unified School District
Catastrophic Leave Bank
Withdrawal Application**

Name: _____ Date: _____

Address: _____

Phone Number: _____

School/Department: _____

Position: _____

Applying for _____ days Dates to be used: _____

Circumstances (give pertinent details): _____

Name of Attending Physician: _____

Physician's Telephone Number: _____

I have used all of my available sick leave. I have read and understand all of the rules regarding the use and administration of Article 23.3 – Catastrophic Leave Bank.

I hereby certify that all statements made herein are true and correct to the best of my knowledge. I understand that a false statement may disqualify me from obtaining days from the Catastrophic Leave Bank.

Signature of Employee or Employee Designee

(PLEASE ATTACH MEDICAL VERIFICATION)