DONATED LEAVE PROGRAM (DLP)
LEAVE REQUEST FORM

Employee name: Employee PID Number:

Serious medical hardship, illness or injury of the: ☐ employee or ☐ immediate family member

If family member, please provide name:

Family member relationship: ☐ spouse ☐ child ☐ parent

Pursuant to the provisions of the Donated Leave Program, I am requesting _____ hours from the donated leave bank to supplement my sick leave account. I confirm that I made a donation to the 2019-20 DLP, and I understand that:

- To be eligible to receive donated leave, my health care provider (or my family member's health care provider) must provide current certification of the serious medical hardship, illness or injury causing my inability to work or requiring my presence to care for the family member.
- My request to use donated leave will be determined by mutual agreement of the Associate Vice President of Human Resources and the College's General Counsel, in consultation with such College personnel as may be necessary. Denial of a request to use donated leave is not subject to the College grievance procedure or any grievance provision(s) of any College collective bargaining agreement.
- Donated leave hours will be converted into an equivalent number of recipient sick leave hours, regardless of differences between participants' pay rates.
- The identity of the donors and recipients will be kept confidential except as required to administer the program or as may be required by law.
- Human Resources will manage the donated leave program and communicate to Payroll the number of hours to be paid to the employee. Payroll will administer the donated time and pay the recipient based on the College's payroll schedule depending on when the forms are approved and sent to Payroll.

By signing below, I acknowledge that I have exhausted or am about to exhaust all of my accrued sick, annual, and/or personal leave.

_____ _____
Donor's Signature Date

SECTION BELOW TO BE COMPLETED BY HUMAN RESOURCES

Leave bank eligibility verified: ☐
(Status of leave balances and verification of donation)

Healthcare provider certification received: ☐
Begin/End Dates _____

Total hours requested: _____

Hours approved: _____ From/to: _____
Hours approved: _____ From/to: _____
Hours approved: _____ From/to: _____
Hours approved: _____ From/to: _____
Hours approved: _____ From/to: _____
Hours approved: _____ From/to: _____

Returned to work (date): _____

HR Signature: _____ Date: _____

Revised 6-9-16