CENTRAL STATE UNIVERSITY

VOLUNTARY LEAVE DONATION PROGRAM

LEAVE RECIPIENT APPLICATION FORM

I. APPLICANT INFORMATION

NAME: ______________________________________________________________
______________________________________________________________

(LAST) (FIRST) (M.I.) (SSN)

DEPARTMENT: ________________________________________________

JOB TITLE: _______________________________ RATE OF PAY $ __________ PER ANNUM [ ] PER HOUR [ ]

Applicant: has [ ] has not [ ] applied for Disability Retirement Benefits. If application has been made, applicant understands NO leave will be advanced.

MEDICAL INFORMATION: Applicant must have medical documentation attached to this application stating beginning date, expected ending date, diagnosis, prognosis and physician's signature.

SELF [ ] FAMILY MEMBER [ ]

If FAMILY MEMBER, please state relationship: _________________________________________

Please provide a brief description of Hardship:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

II. LEAVE BALANCE

ANNUAL LEAVE: ____________ # HOURS

SICK LEAVE: ____________ # HOURS

The above statements are certified true and accurate. Applicant agrees to the public release of his/her name to assist management’s efforts to collect donated leave.

Applicant’s Signature: __________________________________________ Date: ______________

1. Use of donated leave is limited to the average number of hours in the employee’s weekly scheduled tour of duty.
2. Donated leave may not be used to supplement state-paid benefit program(s) (i.e. Disability Leave, Adoption/Childbirth Leave and/or Worker’s Compensation).
3. Donated leave may not be extended beyond a sixty (60) working days period for any one illness and/or medical condition.
III. SUPERVISOR ENDORSEMENT

Date all Paid Leave will be exhausted: ____________________________

I Do [ ] Do not [ ] recommend approval of the employee’s absence from the work place.

I Do [ ] Do not [ ] recommend approval of this application based upon the hardship as described by the applicant.

I do not recommend approval for the following reason(s): ______________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

Supervisor’s Signature: ______________________________________________ Date: _______________________

IV. HUMAN RESOURCE’S REVIEW

PERSONNEL: __________________________

(Signature) (Date)

VICE PRESIDENT
ADMINISTRATION AND FINANCE: __________________________

(Signature) (Date)

Approved: YES [ ] NO [ ]

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 103-103, U.S.C. 6332, Title 5 and EO 9397.
PRINCIPLE PURPOSE: Used primarily by management and the payroll office to identify records properly associated with the leave transfer program. May also be disclosed to a national, state, or local law enforcement agency where there is an indication of a violation or potential violation of civil or criminal law, rule, or regulation; or to another agency or court when the government is part of a suit. SSN is used for positive identification.
ROUTINE USES: None
DISCLOSURE: Disclosure is voluntary. However, failure to do so may prevent proper administration of the leave transfer program.