



DOUGLAS COUNTY

Employee ID: _____

Request to Receive Donated Leave DONATED LEAVE PROGRAM

After completion by the employee or individual applying on behalf of the employee, submit to the employee's Elected Official/Department Head for approval and signature. The Elected Official/Department email the completed form to donated_leave@douglascounty-ne.gov for final review.

Requestors Name (please type/print): _____

Job Title: _____ Employee I.D. _____

Office/Department: _____ Primary Phone: _____

I hereby request to receive donated leave under the Douglas County's Donated Leave Program. I certify

1. I am a non-probationary employee,
2. unable (expect to be unable) to perform duties due to my own serious health condition (not job related), or due to the serious health condition of my: parent spouse, or child,
3. have been authorized to be absent from work due to this health condition,
4. do not have sufficient accrued vacation and sick leave for this absence,
5. will have 80 or more hours of Leave Without Pay (LWOP) in addition to the depletion of my accrued vacation and sick leave balances, and
6. have provided a medical certification form to Human Resources certifying the nature of the serious medical condition.

Accrued/unused leave balance as of last pay period. Vacation: _____ Sick: _____

Choose **ONE** of the following four options:

Employee authorizes advertisement of his/her name, position, department, and a description of the health condition in a posted notice. Provide description to advertise: _____

Employee authorizes advertisement of name, position, and office.

Employee authorizes advertisement of position and office.

Employee does NOT want any advertisement, as he/she has knowledge of interested donors and will notify the donors when eligibility is established.

I understand and agree to the terms of the Donated Leave Policy. Specifically, I understand that there are no guarantees as to the number of hours of donated leave which will be provided, that the maximum donated leave at any one time is 480 hours, that donated leave shall not exceed the hours needed, and that due to the voluntary nature of donations all donor identities must remain confidential.

Employee/Individual Applying on Behalf of Employee

Date

Printed Name of Individual Applying on Behalf of Employee

Phone #

ELECTED OFFICIAL / DEPARTMENT HEAD REVIEW:

I certify:

- 1) the employee has been/will be granted approved absence due to his/her request,
- 2) the personal health condition is not job related, and
- 3) the employee has or is expected to accumulate 80 or more hours of Leave Without Pay (LWOP) due to this health condition in addition to depleting his/her earned vacation and sick leave balances.

I reviewed the information provided, and the employee is eligible to receive donated leave.

Approve Disapprove

Elected/Department Approver/Designee

Date

If disapproving, why? _____

List date employee accumulated/will accumulate 80 hours of LWOP: _____

Email to: donated_leave@douglascounty-ne.gov

For HR Use:

Human Resources: Approve Disapprove

Human Resources Director/Designee

Date