WV DIVISION OF PERSONNEL **LEAVE DONATION PROGRAM**

APPLICATION TO RECEIVE DONATED LEAVE

PART I – Applicant Information: To be completed by the applicant or designee.

PLEASE PRINT OR TYPE

1. Name:		2. Social Security Number:
3. Agency:	4. Section:	5. Unit:
6. Work Phone:	7. Home Phone:	

8. Reason for Request: ❒ Personal Medical Condition 8a. Work-related? ❒ Yes ❒ No

❒ Medical Condition of Immediate Family Member 8b. Relationship: _____

The reason for the request must be verified by the physician or medical practitioner treating the individual with the medical condition. The physician or medical practitioner must provide all of the information requested on the back of this form (PART III) and he/she must sign and date the form.

9. In applying for leave donations, I agree to have the following information published: my name, the agency I work for, the reason for my request, my last day at work, the date my leave available for this absence was or will be exhausted, and the expected duration of my absence.

9a. Signature: _____ 9b. Date: _____

9c. Completed by: ❒ Applicant ❒ Designee (specify): _____

10. **OPTIONAL: TO BE COMPLETED ONLY BY THE APPLICANT.** As part of my application for leave donations, I further request that you also publish the following information regarding my medical emergency exactly as I have written it in the space below.

10a. Signature: _____ 10b. Date: _____

PART II – To be completed by the applicant's Appointing Authority or designee.

1. Does the applicant receive annual and sick leave as a benefit of employment? ❒ Yes ❒ No
2. For this absence, is the applicant receiving/eligible to receive Workers' Compensation benefits, or is he/she receiving Social Security Disability benefits? ❒ Yes ❒ No
3. The applicant's leave available for this absence was/will be exhausted on (date): _____.
4. The applicant, according to the information provided in **PART III,** is expected to be absent from work until (date): _____.
5. The leave of absence is: ❒ Medical (Self) ❒ Personal (Immediate Family)
6. The applicant is: ❒ **ELIGIBLE** to receive the leave donation.

QUESTIONS? Please call the person named in item 8.

❒ **NOT ELIGIBLE** to receive the leave donation.

6a. **REASON:**

7. FIMS account information for recipient: _____.
8. Certified by: _____ 9. Date: _____
10. Title: _____ 11. Phone: _____

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PART III – To be completed by patient's physician or medical practitioner.

The employee named in Part I, 1 has applied to receive donations of annual leave through the Leave Donation Program established by the West Virginia Division of Personnel. You are requested to complete the information below for your patient, either the named employee or a member of the named employee's immediate family. If your patient is the named employee, please complete items 1, 2, 3, 4a, 5a, 6, 7, 8, and 9. If your patient is a member of the named employee's immediate family, please complete items 1, 2, 3, 4b, 5b, and 9.

PLEASE PRINT OR TYPE

1. Patient's name:

2. Most recent date of examination:

3. The patient is/was: ❒ Under My Professional Care **FROM** **TO**

❒ Hospitalized **FROM** **TO**

4. The patient is:

❒ 4a. **EMPLOYEE**

The patient has been incapacitated from performing his/her job duties

FROM **TO**

❒ 4b. **FAMILY MEMBER OF EMPLOYEE**

The absence of the named employee from work has been necessitated by the medical condition of the patient

FROM **TO**

5. Return to duty information:

5a. The patient has resumed or may resume **full duty employment**, with no restrictions on work activities beginning (date):

_____

5b. The patient will no longer need the care/attendance of the named employee which would require the absence of the named employee from work beginning (date):

_____

[NOTE: Please give a date, even if it is approximate. As an alternative, you may give the date you will next evaluate the patient's condition.]

6. If the patient is not able to return to full duty employment, can the patient return to work at less than full duty?

❒ No ❒ Yes If yes, period of partial incapacity: **FROM** **TO**

7. Describe in detail any limitations or restrictions on the ability of the employee to work. Please list any assistive devices or equipment or any other type of accommodation the employee requires to perform his/her job duties.

8. Will this illness or injury **permanently** prevent the employee from returning to work?

❒ Yes ❒ No

9. **PHYSICIAN'S OR PRACTITIONER'S NAME:** _____

ADDRESS: _____ **PHONE:** _____

SIGNATURE: _____ **DATE:** _____

[YOUR AGENCY'S LETTERHEAD]

NOTICE OF ELIGIBILITY TO RECEIVE LEAVE DONATIONS

_____, an employee of the _____,
(applicant's name) (agency, section, unit)

is eligible to receive voluntary donations of annual leave. _____ has
(applicant's name)

been absent from work since _____, and his/her available leave was
(last day of work)

or will be exhausted on _____. _____'s
(last day of pay) (applicant's name)

absence is due to
- ❒ his/her own illness or injury
- ❒ the illness or injury of his/her _____
(relationship)

and he/she is expected to be be off work until _____.
(expected date of return)

_____ has requested that the following additional information be pub-
(applicant's name)

lished with this notice.

Any employee wishing to make a voluntary donation of annual leave to _____
(applicant's name)

should complete a Leave Donation Application and submit it to the individual responsible for keeping

leave records in his/her work unit.

_____ _____
SIGNATURE OF APPOINTING AUTHORITY **DATE**