Douglas County, Nebraska
REQUEST TO RECEIVE DONATED LEAVE
DONATED LEAVE PROGRAM

The applicant or individual applying on behalf of the applicant completes and signs Section 1. After completing Section 1, forward to the applicant's Elected Official / Department Head, who completes Section 2. After Sections 1 and 2 have been completed, send form to Douglas County Human Resources, 505 Civic Center, where Section 3 will be completed.

SECTION 1 TO BE COMPLETED BY APPLICANT OR INDIVIDUAL APPLYING ON BEHALF OF APPLICANT

I hereby request that I be allowed to receive donated leave under the Douglas County's Donated Leave Program. I certify that (1) I am a non-probationary employee; (2) I am unable (or expect to be unable) to perform duties due to my own serious health condition, that is not job related, or due to the serious health condition of my: ☐ parent ☐ spouse, or ☐ child
(3) I have been authorized to be absent from work due to this health condition; (4) I do not have sufficient earned vacation and sick leave to cover this absence; (5) my absence because of this health condition will result in the accumulation of 80 or more hours of Leave Without Pay (LWOP) in addition to depletion of my earned annual and sick leave balances; and (6) I have provided a medical certification form from a doctor certifying the nature of the serious medical condition.

Applicant's Last Name: ______________________ First: ____________________ MI: ______

Applicant **must choose** only **ONE** of the following four options:

☐ Applicant authorizes the advertisement of his or her name, position, office, and a description of the health condition in a posted notice. **Provide the description to be released below:**

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☐ Applicant does **NOT** authorize the advertisement of a description of the health condition in a posted notice. **(Only applicant's name, position, and office will be published.)**

☐ Applicant does **NOT** authorize the advertisement of his or her name and a description of the health condition in the notice. (**Only applicant's position and office will be published).**

☐ Applicant does **NOT** want any notice posted requesting voluntary donations of annual leave, as he or she has personal knowledge of interested donors and will notify the donors when his or her eligibility is established.

Employee ID or last 4 digits of Social Security Number: ______________

Contact Telephone Number (include area code): ______________

Job Title: ____

Department: ____

Earned/Unused Leave Balances at End of Last Pay Period: Annual: ________ Sick: ________

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.

____ ______________

Signature of Applicant or Individual Applying on Behalf of Applicant **Date**

Name of person signing if not employee (please print full name): ______________________________

Phone number of person signing on behalf of applicant (include area code): ______________

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SECTION 2 TO BE COMPLETED BY ELECTED OFFICIAL / DEPARTMENT HEAD

Elected Official / Department Head Review

I certify that (1) the applicant has provided a medical certification form from a doctor that sufficiently documents a serious health condition and the need for extended absence because of such condition; (2) the applicant has been or will be granted approved absence due to this condition; (3) the personal health condition is NOT job related; and (4) the employee has or is expected to accumulate 40 or more hours of Leave Without Pay (LWOP) due to this condition in addition to the depletion of his or her earned annual and sick leave balances.

Attach Medical Certificate

I have reviewed Section 1 and based on the information provided, the applicant is eligible to receive donated leave.

☐ **Approved** ☐ **Disapproved**

____ _______________
Elected Official / Department Head Signature Date

If disapproved, provide reason:

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Enter date the applicant accumulated (or will accumulate) 80 hours of Leave Without Pay (LWOP) due to this personal health condition:

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SECTION 3 TO BE COMPLETED BY HUMAN RESOURCES

Human Resources Approval: ☐ **Approved** ☐ **Disapproved**

____ _______________
Director of Human Resources / Designee Date