

## LEAVE DONATION

Franklin County Board of Commissioners employees who are not covered by a collective bargaining agreement and who are eligible to accrue and use sick leave may participate in a leave donation program.

Collective bargaining agreements containing a leave donation program may provide the option of participating in leave donation with employees covered by other agreements or with non-bargaining employees. If the leave donation is between a non-bargaining employee and a bargaining employee, the provisions of the recipient's (donee's) program will apply.

The leave donation program allows employees to voluntarily provide assistance to co-workers who are in critical need of leave due to a serious illness or injury of that employee or a member of that employee's immediate family. For purposes of this leave donation program only, immediate family is defined as an employee's spouse, domestic partner, child, stepchild, sibling, parent, or person who stands in place of a parent.

Eligible employees can request donated leave. Requests are considered collaboratively by the employee's agency director (operational and eligibility considerations) and the Director of Human Resources (medical considerations). If the request is approved, the employee may receive donated leave up to the number of hours specified, but not to exceed a total of 2080 hours.

The leave donation program is administered pay period by pay period and any leave accrued by the recipient must be used in the next period before using donated leave. Hours donated through the program are on an hour for hour basis.

### Application

Submit a written request for leave to your agency director. Your agency director will collaborate with the Department of Human Resources Director in the approval process. Your director will examine several factors including whether you have:

- a history of sick leave abuse;
- no accrued leave;
- been approved to receive other state/county paid wage related benefits; and
- applied for any paid leave, workers' compensation, or benefits program for which you are eligible.

(more)

## Leave Donation

## Board of County Commissioners Policy Number: BOC-44.01

Provide a supporting Medical Certification to Human Resources. For approval, the Department of Human Resources will determine if the medical condition qualifies as serious.

A serious illness or injury is one that generally requires surgery with a prolonged recovery period, or involves multiple traumatic injuries, or is a serious mental illness, or is life threatening. Examples include heart attack, certain cancer conditions, and organ transplants.

Normal pregnancies, chronic conditions, and short-term acute conditions are not considered for leave donation.

### Donor Eligibility

Must be an active employee during the pay period leave is donated.

Complete Donor Application form specifying the recipient.

Donate leave voluntarily.

Donated leave will not be returned.

Follow guidelines for donation amount and maintained leave balance.

- Donate a minimum of eight (8) hours; and
- Retain a sick leave balance of at least eighty (80) hours – during all cycles of the donation process. Otherwise, specify other types of paid leave to be donated (i.e., vacation, compensatory, personal).

May not receive money or any other consideration for your donation.

### ***References and Related Comments***

*Employee must return to work as soon as the medical condition necessitating the use of donated leave permits.*

*Donated leave is considered sick leave, but it cannot be converted into a cash benefit or used for the Wellness Incentive Program.*

*Donated leave does not count toward completion of the probationary period of an employee who receives the leave during his or her probationary period.*

**LEAVE DONATION PROGRAM – APPLICATION FORM**

<b>NAME (PRINT)</b>	<b>LAST</b>	<b>FIRST</b>	<b>MIDDLE INITIAL</b>	<b>DATE:</b>

**EMPLOYING AGENCY:**

\_\_\_\_\_

I REQUEST LEAVE BEGINNING \_\_\_\_\_ A.M. \_\_\_\_\_, \_\_\_\_\_, 20\_\_ AND  
P.M.  
ENDING \_\_\_\_\_ A.M. \_\_\_\_\_, \_\_\_\_\_, 20\_\_ FOR  
P.M.

**THE FOLLOWING REASON:**

**CHECK ONE:**

- SERIOUS PERSONAL ILLNESS OR INJURY** \_\_\_\_\_
- SERIOUS ILLNESS OR INJURY IN IMMEDIATE FAMILY** \_\_\_\_\_

If my application for the leave donation program is approved, I hereby give permission for the agency director and other agency management to inform my coworkers of my critical need for leave.

\_\_\_\_\_  
**SIGNATURE OF EMPLOYEE**

OR

\_\_\_\_\_  
**SIGNATURE OF IMMEDIATE FAMILY MEMBER (IF APPLICABLE)**

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**FAMILY OR MEDICAL LEAVE**

Please check here if any of the above requests for leave are for a family or medical leave (FMLA) per the policy in the employee handbook or union contract, where applicable.

If so, please attach the required documentation.

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**ADMINISTRATIVE ACTION:**

- |                                      |                                      |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Approved    | <input type="checkbox"/> Approved    |
| <input type="checkbox"/> Disapproved | <input type="checkbox"/> Disapproved |

_____ AGENCY DIRECTOR	_____ DATE	_____ HR DIRECTOR	_____ DATE
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**REMARKS:** \_\_\_\_\_

\_\_\_\_\_

**MAXIMUM TOTAL LEAVE DONATION HOURS APPROVED** \_\_\_\_\_

**LEAVE DONATION PROGRAM – DONOR FORM**

<b>NAME (PRINT)</b>	<b>LAST</b>	<b>FIRST</b>	<b>MIDDLE INITIAL</b>	<b>DATE:</b>

**EMPLOYING AGENCY:** \_\_\_\_\_

**LEAVE DONATION FOR PAY PERIOD ENDING** \_\_\_\_\_, \_\_\_\_\_, 20\_\_

<u>NUMBER OF HOURS DONATED</u>	<u>TYPE(S) OF LEAVE DONATED</u>
_____	Vacation
_____	Sick leave
_____	Personal leave
_____	Compensatory time
_____	<b>Total hours donated (must equal 8 or more hours)</b>

**PERSON TO RECEIVE LEAVE**

<b>EMPLOYEE NAME (PRINT)</b>	<b>LAST</b>	<b>FIRST</b>	<b>MIDDLE INITIAL</b>
_____	_____	_____	_____

**EMPLOYING AGENCY:** \_\_\_\_\_

**CERTIFICATION**

I hereby certify that this request is made voluntarily. I was not coerced, intimidated or financially induced into donating leave. By signing I hereby relinquish all rights to the leave shown above and the benefits accruing to or attached to the same. I understand that the donation of leave is irrevocable and irreversible and that no leave will be refunded to me. I certify that I will have a remaining balance of 80 hours or more of sick leave after making this donation.

\_\_\_\_\_  
**SIGNATURE OF DONATING EMPLOYEE** \_\_\_\_\_  
**DATE**

**OCSEA EMPLOYEES ONLY:**

**EQUIVALENT HOURS DONATED BY DONOR:** \_\_\_\_\_

Donor's Hourly Rate  
Donee's Hourly Rate X # Hours Donated = Equivalent Hours to be Received by Donee