OHIO UNIVERSITY
Human Resources

Request to Receive Donated Leave

Employee/Recipient Name	
Employment Type	Administrator ☐ Non-Bargaining Classified ☐ Faculty ☐
Hours Requested	_____ (A maximum of 160 hours or 20 days is allowed in a fiscal year)
Reason for Request	Employee Illness/Injury ☐ Family Member Illness/Injury ☐
If Request if For Family Member	Name of Family Member _____ Relationship _____

I hereby request the above listed number of paid leave hours from the paid leave pool for me or my family members serious illness or injury. The purpose of my request meets the conditions of the leave donation program as outlined below:

- A serious illness or injury is a non-workers' compensation related health condition of the employee or family member (as defined by the Family Medical Leave Act) which incapacitates the employee or family member for a period of at least ten (10) consecutive days.
- Serious illness or injury includes conditions resulting in absences to receive multiple treatments (including any period of recovery) either for surgery, injury, or chronic conditions. Examples may include care for chronic conditions (diabetes, asthma, etc.), conditions that require multiple periodic treatments (cancer, physical therapy, etc.), and/or conditions for which treatment may not be effective (terminal disease, stroke, etc.).

Employee's Signature: _____ **Date:**_____

Physician Certification

I hereby certify that the employee and/or family member listed above has an illness or injury (as defined above) that results in a period of incapacity of at least ten (10) consecutive days.

Physician Signature:_____ **Date:**_____

Physician Name (Print): _____

For UHR use ONLY

Recipient Eligible?: ☐ Yes ☐ No Recipient Date of Hire: _____ Admin ☐ Classified ☐ Faculty ☐

_____ Recipient has **not** received maximum number of hours (160.0) Effective Date: _____

_____ Recipient **has** received maximum number of hours (160.0) Effective Date: _____

_____ Number of Hours Approved From The Pool: _____ Effective: _____

_____ Number of Hours added to recipient accrual Effective Date: _____ Approver Initials _____

_____ Date Recipient Notified: _____ Date Donor Notified: _____
_____ Vacation Leave Donation Spreadsheet Updated: Effective: _____

UHR Approver Signature _____ **Date:**_____

UHR Approver Name: _____