

REQUEST TO RECEIVE DONATED LEAVE

Approval of a request for donated leave is dependent on shared leave availability and taking into consideration the best interest of the county. The Shared Leave Committee reserves the right to review the application and leave status at anytime during the absence of the employee.

I, _____, anticipate being absent from work for an extended period of time (at least six weeks) due to a non-job related illness or injury which is medically catastrophic (e.g. the illness/injury is extremely serious, totally incapacitating, or life-threatening) and will force me to exhaust all paid leave during this period of time. I am asking that the County make this need known to other employees.

A Certification of Health Care Provider form must be completed and attached before the application will be considered.

I give permission for the general nature of my medical condition as described below to be released to other employees for the purpose of receiving donations. I can elect not to have my medical information shared by marking no.

Yes _____ No _____

If yes, briefly describe nature of medical condition:

Estimated dates that I will be unable to work:

From _____ to _____

Number of hours requested _____

Current leave balance as of _____

Vacation hours: _____

Sick hours: _____

Holiday hours: _____

Note: In the event that an employee in need of leave is incapable of completing this form, the Department Head may do so with the verbal permission of the employee. In such a case, medical information will not be released.

To the extent that is relevant to this application, I give approval for the department head to discuss performance issues with the committee. I understand that administrative decisions will be made by the Shared Leave Committee with no right to appeal. **I also understand it is my responsibility to notify Human Resources when I return to work.**

Employee's Signature _____ **Date** _____

Social Security # _____ Phone number _____

Address _____

Department Head _____ **Date** _____

Comments to committee: _____

Committee Chair _____ **Date** _____

Approved _____ Denied _____

Forsyth County Shared Leave Program Certification of Health Care Provider

Form to be completed by health care provider and returned to employee.
All information will be kept confidential and shared only as authorized by employee.

Employee Name	Patient's Name (if different from employee)
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Forsyth County has a program allowing employees to donate leave to other employees who are experiencing an extended catastrophic medical condition, or who have an immediate family member who is experiencing an extended catastrophic medical condition. This illness has to be **non-job related, extremely serious, totally incapacitating or life threatening and for which the employee anticipates being absent from work for at least six weeks**. In order to determine if our employee qualifies, we need the following information.

1. Describe the medical facts that would support the application for catastrophic shared leave:

2. Please provide the probable duration of the condition from _____ date to _____. If you are uncertain about the duration please provide information that would help determine the qualifications for above described leave, which requires at least six (6) weeks' absence.

3. Please share any other relevant information about why this health problem meets the catastrophic medical condition.

4. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

Signature of Health Care Provider	Type of Practice	Date
Printed Name of Health Care Provider	Telephone Number	

TO BE COMPLETED BY THE EMPLOYEE NEEDING LEAVE TO CARE FOR A FAMILY MEMBER: State the SPECIFIC care you will provide and an estimate of the period during which care will be provided:	
Employee Signature	Date