

**APPLICATION TO RECEIVE DONATED LEAVE**

PLEASE PRINT OR TYPE

**PART I – APPLICANT INFORMATION: To be completed by the applicant or designee.**

Name:		Employee's Oasis Number:	
Agency:		Work Phone:	Home Phone:
Section (and Unit if applicable):			
Reason for Request: <input type="checkbox"/> Employee's Personal Medical Condition <input type="checkbox"/> Immediate Family Member's Medical Condition Relationship:		The reason for the request <b>must</b> 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.	
In applying for leave donations, I agree to have the following information published:			
<ul style="list-style-type: none"> <li>• My Name</li> <li>• The agency for which I work</li> </ul>		<ul style="list-style-type: none"> <li>• My last day at work</li> <li>• The date my available leave was/will be exhausted</li> <li>• The reason for my absence</li> <li>• The expected duration of my absence</li> </ul>	
Signature		Date:	
Completed by: <input type="checkbox"/> Applicant <input type="checkbox"/> Designee (specify):			
<b>OPTIONAL - To be completed ONLY by the applicant:</b> 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:			
Signature		Date:	

**PART II – EMPLOYER DETERMINATION: 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?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. <b>For this absence:</b> Is the applicant receiving/eligible to receive Worker's Compensation benefits, or is he/she receiving Social Security Disability benefits?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. The applicant's available leave for this absence was/will be exhausted on:		Date:	
4. The applicant, according to the information provided in PART III of this form, is expected to be absent from work through:		Date:	
5. This leave of absence is for the following reason:		<input type="checkbox"/> Medical Condition: Employee <input type="checkbox"/> Medical Condition: Immediate Family Member	
6. The applicant's eligibility determination is:		<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> NOT ELIGIBLE: explain below	
7. OASIS account information for recipient:			
8. Certified by:		10. Phone:	
9. Title:		11. Date:	

