ALCORN STATE UNIVERSITY
Alcorn State, Mississippi

Department of Human Resources

Guidelines for Donating Leave

1. Any employee may donate a portion of his or her earned personal or medical leave to another employee who is suffering from a CATASTROPHIC injury or illness, or to another employee who has a member of his or her immediate family who is suffering from a CATASTROPHIC injury or illness.

2. CATASTROPHIC injury or illness means "a life-threatening injury or illness of an employee or a member of an employee's immediate family which totally incapacitates the employee from work, as verified by a licensed physician, and forces the employee to exhaust all leave time earned by that employee, resulting in the loss of compensation for the employee.

3. In order for an employee to be eligible to receive donated leave, the employee must have been employed at ASU for a total of at least twelve months on the date on which the leave is donated.

4. The maximum amount of earned personal leave that an employee may donate to any other employee may not exceed a number of days that would leave the donor employee with fewer than seven (7) days of personal leave. The maximum amount of earned medical leave that an employee may donate to any other employee may not exceed 50% of the earned medical leave of the donor employee.

5. All donated leave shall be in increments of not less than twenty-four (24) hours, i.e., 24 hrs.; 48 hrs.; 72 hrs.; 96 hrs.; 120 hrs.; etc.

ALCORN STATE UNIVERSITY
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DONATED LEAVE AUTHORIZATION

Date: _____

I, _____ Social Security No: _____
(Donor Employee)
designate to _____ Social Security No: _____
(Recipient Donor)
_____ hours of my personal leave and/or _____ hours of my major medical leave. According to the Office of Human Resources, I have a balance of _____ hours personal leave and a balance of _____ hours major medical leave, as of period ending _____.

(Note: Leave donated must be in 24-hours increments. The 24-hours may be a combination of personal and major medical leave.)

I donate these hours to be used for the catastrophic injury or illness to either the recipient employee or his or her immediate family requiring the services of a licensed physician for an extended period of time and that has forced the recipient employee to exhaust all leave time earned by that employee resulting in a loss of compensation. I understand that if the total amount of leave I donate is not used by the recipient employee, the donated leave will be returned to me on a pro-rata basis, based on the ratio of the number of days of leave donated by each donor employee to the total number of days of leave donated by all donor employees.

Donor's Signature: _____ Date: _____

Approved by:

_____ Date: _____
(Donor's Department Head/Supervisor)

Note:

Catastrophic injury or illness is defined as a life threatening injury or illness which totally incapacitates the individual or the employee from work. Conditions that are short-term in nature, including, but no limited to, common illnesses such as influenza, and the measles, and common injuries ARE NOT catastrophic. Chronic illnesses or injuries, such as cancer or major surgery, which result in intermittent absences from work and which are long-term in nature and require long recuperation periods maybe considered catastrophic.

(Note: Eligible family member means: spouse, parent, step parent, sibling, child or stepchild.)

Approved by:

_____ Date: _____
(Recipient's Department Head/Supervisor)

_____ Date: _____
Director of Human Resources

(**To be completed by Human Resources only**)

Recipient did not use all of the donated leave. Consequently, donated leave is being returned to the donor in the amount of:

Major Medical _____ hours Personal _____ hours

(5/2003)

ALCORN STATE UNIVERSITY
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Medical Certification Form for Donated Leave

Section I

Employee Name: _____ SSN: _____

Name of Eligible Family Member Requiring Employee's Absences (if other than employee):
_____

Relationship to Employee: _____

Date(s) Leave Requested: _____

_____ _____
Employee's Signature (or Personal Representative) Date

(Note: Eligible family member means: spouse, parent, step parent, sibling, child or stepchild.)

To be completed by Doctor or Health Care Provider:

Section II
Doctor or Health Care Provider Certification

(Note: Catastrophic injury or illness is defined as a life threatening injury or illness which totally incapacitates the individual or the employee from work.)

Is this illness or injury considered catastrophic? _____ Yes _____ No If "Yes" please answer the questions listed below.

	Yes	No	N/A
Is the employee able to perform the essential functions of his/her position?	❑	❑	❑
Is it necessary that this employee be absent to care for a family member?	❑	❑	❑
Is intermittent leave or a reduced work schedule medically necessary?	❑	❑	❑

Date illness began: _____ Estimated length of illness: _____

Please describe the treatment/prognosis required for the employee or family member. _____

_____

_____

In your professional opinion, when will the employee be able to return to work? _____

_____ _____
Signature of Doctor/Health Care Provider Date

_____ _____
Printed Name and Address of Above Telephone Number

(5/2003)