

**EMERGENCY AUTHORITY ONLY  
APPLICATION TO RECEIVE DONATED LEAVE**



**Employee Section:**

Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_  
(Please print)

Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

The request is based upon:     My own medical emergency     A family member's medical emergency

Applying for:  State Disability Insurance     Paid Family Leave     UNUM     Other \_\_\_\_\_

I certify that the above information is true and that I have read the employee acknowledgement below:

\_\_\_\_\_  
Name Date

**Department Human Resources Section:**

Type of leave: \_\_\_\_\_ Leave Start Date: \_\_\_\_\_

Date accrual have/will exhaust \_\_\_\_\_ Hourly Pay Rate \_\_\_\_\_

\_\_\_\_\_  
Analyst/Tech Name Date

**Employee Benefits Section:**

This request for donation is:  Approved     Denied, reason: \_\_\_\_\_

Leave donation is approved for the following period: \_\_\_\_\_

**Donation Valuation:**

Pay Rate: \_\_\_\_\_ x \_\_\_\_\_ donated hours = \$ \_\_\_\_\_

\_\_\_\_\_  
Approver Name Date

**Employee Acknowledgment:**

I acknowledge that I have read and understand the Leave Donation Policy. I understand that any decision to approve or deny my request by the County shall be final and cannot be subject of a grievance. I understand that donated leave shall only be approved for use commencing from the date I provide all of the required information to the County and will end on the last day of my absence from work as stated on my physician's certificate.

I acknowledge and understand that this request must include:

1. Written physician's certificate of the medical emergency with duration of required time off.
2. If on leave to care for a family member, a physician's note explaining why the emergency requires my personal presence during normal working hours and cannot otherwise be reasonably accommodated by the department.
3. Written verification of approval or denial of State Disability Insurance (SDI), Paid Family Leave (PFL), and/or UNUM, if I am covered.
4. Information pertaining to any monies I am receiving, or may receive, as a result of workers' compensation, accident insurance, income replacement policies, or third-party reimbursement.

I understand that leave donations received by me will be included in my gross income for the tax year in which received and will be reported as taxable income on my W-2. I understand that leave donations received by me have a cash value only and do not cause me to be eligible for insurance or other benefits, and do not absolve me from paying for my own insurance premiums if I am determined to be ineligible for FMLA or Workers' Compensation benefits.