Compassionate Donation
Receiver Form

Employee requesting eligibility to receive Compassionate donation: Complete the following section and give to your Supervisor for review.

Name of Receiving Employee	Receiving Employee USNH ID#	Campus Telephone Number
Receiving Employee's Department / Dept Address	Receiving Employee's Employment Status (OS, PAT, EE, AA, non-AAUP/ fiscal year Faculty)	

I understand I may be eligible to receive compassionate donation if all of the conditions below apply:

a. I have submitted a completed Certification of Health Care Provider form to the Office of Human Resources, and it has been approved as Family and Medical Leave.
b. The absence is due to my own serious health condition or that of an immediate family member, or to care for a newborn or a new adopted/foster child, or for Military-Related leave, as defined under the FMLA and will require me to be absent from work for a minimum of 30 consecutive calendar days (intermittent leave does not apply).
c. I have exhausted, or expect to exhaust, all earned time/annual leave, sick leave/sick pool and compensatory time; and must be facing a minimum of five days of unpaid leave. (I may be eligible to receive compassionate donation to care for family member, even though I have sick leave/sick pool balance).
d. The total number of received days has not exceeded 20 working days in the 12-month period immediately preceding the receipt of this compassionate leave.
e. I expect to return to work for a period of at least 30 calendar days following the leave.

I project that my accumulated leave (and compensatory time for Operating Staff) will be exhausted on:

_____
Date

The expected dates of my leave are _____ to _____

I request compassionate donation for a period up to _____ hours (OS) or _____ days (PAT/EE)

I consent to the written or oral disclosure of my name to eligible donors for compassionate donation purposes _____ yes _____ no

Employee's signature_____ Date _____

Supervisor: Please verify the receiving employee's leave balance(s) below. If the employee is eligible, complete the following section and submit to the Office of Human Resources.

I certify that the employee leave balances are as follows:

For OS Earned Time: (hours) _____ (date exhausted) _____

Comp Time: (hours) _____ (date exhausted) _____

For Exempt Vacation/annual: (days) _____ (date exhausted) _____
(PAT, EE, AA, non-AAUP fiscal year faculty)

I certify that this employee _____*meets* _____*does not meet* the recipient leave balance criteria*

* must exhaust, or expect to exhaust, all earned time/annual leave, sick leave/sick pool, and compensatory time; and must be facing a minimum of five days of unpaid leave related to this absence

Supervisor's signature_____ (date) _____

Supervisor's Name (Please Print) _____

Human Resources authorization, based on leave data certified by supervisor above.

Approved ____ Not approved ____ ECLS ____ % Time ____ DOH ____

_____ _____

Signature - HR Partner Date

cc: employee, supervisor, BSC (if request approved by HR)