

# **NEW MEXICO HIGHLANDS UNIVERSITY**

## **EMPLOYEE LEAVE DONATION PROGRAM**

### **PURPOSE**

This Employee Leave Donation program provides assistance to an employee for the hardship caused by a serious health illness or injury that results in the employee exhausting all leave time earned by that employee and to lose all compensation including paid compensation benefits from the University. Regular full-time and regular part-time employees paid from non-restricted funds who have completed the University's probationary period and who are eligible to accrue sick leave may apply for sick leave from the Employee Leave Donation Program subject to the other provisions outlined in this Plan Document. Faculty, employees paid from restricted funds, and temporary employees are not eligible to participate in the Employee Leave Donation Program.

### **DEFINITIONS**

1. A serious health illness or injury is a severe condition or combination of conditions affecting the mental or physical health of the employee or the employee's immediate family that requires the services of a licensed practitioner for a prolonged period of time and that forces the employee to exhaust all leave time earned by that employee and to lose compensation including paid compensation benefits from the University for the employee.
2. Licensed practitioner means medical doctor or psychologist who is practicing within the scope of his/her professional license.
3. Immediate family is defined as spouse, parent, mother or father-in-law, child (natural, adopted, marriage, or foster), brother, sister, or any other person residing in the same household of employee. The individual should be totally dependent upon the employee for personal care or services on a continuing basis.
4. The Employee Leave Donation Program Administrator is the Executive Director for Human Resource and Affirmative Action Services or designee.

### **ELIGIBILITY**

1. All regular full and part time non-faculty/non-restricted fund employees who have completed the University's probationary period and are eligible to accrue sick leave may participate in the Employee Leave Donation Program subject to the other provisions of this Plan.
2. An employee may apply only once for each serious illness or injury within a calendar year, unless the maximum of 90 calendar days of donated sick leave was not received.
3. This Program does not cover time off due to a job-related injury covered by Worker's Compensation Benefits.

4. Any amount of Family and Medical Leave Act leave an employee would be eligible to take will be reduced by any Employee Leave Donation Program leave the employee takes.
5. If sick leave abuse is evident, the employee is disqualified from participation in the program.

### **CONTRIBUTION OF TIME**

1. To contribute time to the Employee Leave Program, an employee must submit a Transfer Form (Exhibit "A") to the Program Administrator. Contributions to the Employee Leave Donation Program are voluntary and are irrevocable and will only be made at the time of an authorized request for assistance.
2. Any eligible regular full or part time employee may donate no more than 40 hours of annual leave in any one calendar year. The employee donating 40 hours of annual leave must have a balance of at least 80 hours remaining in their annual leave account after the donation.

### **WITHDRAWAL OF TIME FROM THE PROGRAM**

1. An eligible employee may apply to the Program Administrator to request donations from employees through the Employee Leave Donation Program. An employee can apply to use the Employee Leave Donation Program for his/her own serious illness or injury or for the illness or injury of a member of his/her immediate family, as defined in this document. The form application is attached hereto as Exhibit "B".
2. All requests for leave from the Program shall be accompanied by a physician's statement specifying the nature of the illness or injury and the approximate duration of the absence on the form attached as Exhibit "C." The Program Administrator reserves the right to request a second medical and/or psychological statement of opinion.
3. An eligible employee may not receive donations from the Employee Leave Donation Program in an amount that exceeds 90 calendar days in any one calendar year.
4. An employee is eligible to participate in the Program if the Program Administrator finds that the employee has exhausted all accrued paid leave including paid compensation benefits because of a serious illness or injury.
5. An employee must be facing at least five (5) days of unpaid leave before an application to participate in the program may be submitted.
6. If it is determined that the employee is eligible to participate in the Program, the Program Administrator shall determine the amount of leave that an eligible employee may require. The Program Administrator shall notify all employees of the request for assistance. Unless the employee gives written permission, the only information released will be the employee's name and number of hours needed. The Program Administrator shall approve/disapprove the application within a reasonable period of time.

7. The employee may use sick leave assigned from the Program in the same manner as accrued sick leave and shall be treated in the same manner and shall be entitled to accrue the same benefits as an employee who uses such accrued sick leave.
8. When an employee using Program hours returns to work prior to using the donated hours, any unused hours revert to the employees making the donation on a pro-rata basis.

### **PROGRAM LEAVE TERMINATION**

1. An employee's receipt of Program leave hours terminates when University employment is terminated. Any unused leave does not become the basis for a lump-sum leave payment to the employee.
2. An employee's receipt of Program leave hours terminates when the employee is eligible for coverage under disability retirement, long-term disability benefits or workman's compensation.
3. An employee's receipt of Program leave hours terminates when the employee's serious injury or illness terminates.

### **ESTATE ENTITLEMENT**

1. The estate of a deceased employee is not entitled to payment of any sick leave from the Employee Leave Donation Program.

**EMPLOYEE LEAVE DONATION PROGRAM APPLICATION FORM**

**(Withdrawal)**

**Employee's Statement**

1. Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_
2. Department \_\_\_\_\_ Supervisor: \_\_\_\_\_
3. If request is for the disability of a dependent, please complete:  
Dependent's Name \_\_\_\_\_ Relationship to employee \_\_\_\_\_  
Does dependent reside in your household? \_\_\_\_ Yes \_\_\_\_ No
4. Last day physically at work \_\_\_\_/\_\_\_\_/\_\_\_\_  
Expected return date \_\_\_\_/\_\_\_\_/\_\_\_\_
5. Accrued Leave available at commencement of absence:  
Sick Leave \_\_\_\_ Annual Leave \_\_\_\_ Compensatory Time \_\_\_\_ Total \_\_\_\_
5. If applicable, on what date do you expect Long-Term disability benefits to commence: \_\_\_\_\_ .
7. Number of hours you are requesting from the sick leave Program? \_\_\_\_\_
8. Nature of Illness? \_\_\_\_\_
9. Is it work related? \_\_\_\_\_
10. Is surgery required? \_\_\_\_\_
11. Surgical procedure required: \_\_\_\_\_
12. Date of onset of current illness: \_\_\_\_\_
13. Have you had this illness previously? \_\_\_\_\_
14. Have you previously requested leave from the Program for this condition?  
\_\_\_\_\_

**Exhibit "B"**

I certify that the above answers are true and correct to the best of my knowledge and authorize any doctor or medical institution having information concerning my illness to release information to New Mexico Highlands University concerning this application.

I certify that I am unable to work due to a severe condition/combination of conditions affecting my mental or physical health or that of my immediate family that requires the services of a licensed practitioner for a prolonged period of time. I further certify that I will exhaust all available leave time and will be required to be placed in a leave without pay status.

Signature of \_\_\_\_\_ Date \_\_\_\_\_  
Employee \_\_\_\_\_

**Important-Complete Certification of Physician Form**  
**Submit Completed form to the Exec. Dir. for HR and AA Services**

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**HUMAN RESOURCE AND AFFIRMATIVE ACTION SERVICES DEPARTMENT**

Received by: \_\_\_\_\_ Date \_\_\_\_\_  
Received \_\_\_\_\_

LTD Filed: \_\_\_ Yes \_\_\_ No      Anticipated commencement \_\_\_/\_\_\_/\_\_\_

Application Approval: \_\_\_ Yes \_\_\_ No

Hours awarded for this application \_\_\_\_\_

Signature:

Program Administrator \_\_\_\_\_ Date \_\_\_\_\_

## Certification of Physician/Psychologist/Psychiatrist

1. Employees' Name: \_\_\_\_\_

2. Patient's Name: \_\_\_\_\_

I authorize \_\_\_\_\_ to release information to the Employee Leave Donation Program Administrator.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

3. Diagnosis (including complications): \_\_\_\_\_

4. Date Condition commenced: \_\_\_\_\_

5. Probable duration of condition: \_\_\_\_\_

6. Check YES or NO to the questions below:

\_\_\_ Yes \_\_\_ No Is inpatient hospitalization required?

\_\_\_ Yes \_\_\_ No Does the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

7. If this certification is for the employee's own seriously-ill condition:

\_\_\_ Yes \_\_\_ No Is the employee able to perform the functions of the employees' position?

\_\_\_ Yes \_\_\_ No Is the employee able to perform work of any kind? If yes, what:

\_\_\_\_\_

8. The definition of a serious health injury or illness is:

A severe condition or combination of conditions affecting the mental or physical health of the employee or the employee's immediate family that requires the services of a licensed practitioner for a prolonged period of time and forces the employee to be absent from work.

In your opinion, do the circumstances of this case meet this definition? \_\_\_ Yes \_\_\_ No

9. Date patient can return to work? \_\_\_\_\_

Name of attending Physician (Print) \_\_\_\_\_

Telephone# \_\_\_\_\_ Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Exhibit "C"**