University of Cincinnati
Application for Leave Donation

Refer to the Leave Donation Policy 21.22

Section I – Employee/Applicant Information – Please print	
Employee Name:	M#:
Immediate Family Member Name (if applicable):	Relationship:

Section II - Certification

I request to receive Leave Donation under the University of Cincinnati Leave Donation Program. I hereby certify that:

- ☐ I am unable (or expect to be unable) to perform work duties due to my serious medical condition or I have an immediate family member whose serious medical condition requires my presence.
- ☐ I have been authorized by a physician to be absent from work due to this condition or a physician has certified the need for me to be present to care for my immediate family member.
- ☐ I will have exhausted all paid time (short and long term sick, vacation, compensatory) balances and without a donation, I will be off work at least 80 hours without pay. Any donated leave will be applied retroactively to the 80 hours unpaid time minimum.
- ☐ If absence is for my own serious medical condition, it is not job related
- ☐ I am not currently receiving disability benefits, disability retirement, or regular retirement and acknowledge that I cannot opt to receive Leave Donation in lieu of one of these benefits. Receipt of any of these benefits will invalidate my eligibility for Leave Donation.
- ☐ I authorize University Health Services (UHS) to contact the physician who has completed the Certification of Healthcare Provider form per FMLA regulations.
- ☐ I have not been counseled or disciplined for an attendance violation within the past 12 months.
- ☐ I understand receipt of donated leave is not guaranteed and that coercion is strictly prohibited.
- ☐ I understand while in an unpaid leave status I will be responsible for paying my portion of benefits (Medical, Dental, Life Insurance, Personal Accident Insurance and Long Term Disability coverage) and I will not accrue any paid time off.

Section III – Department Head Certification

Leave Balances as of the end of the last pay period:

Vacation:	Combined Sick:	Comp Time:

I hereby certify (check all that apply):

- ☐ The applicant has not been counseled or disciplined for an attendance violation within the last 12 months.
- ☐ The applicant is in “no pay” status and is expected to be out of pay for 80 hours.
- ☐ The applicant is not paid from a Federal Grant fund.
- ☐ The applicant is paid from a Federal grant fund. Please charge pay to account number:

Please contact the Payroll Department with questions regarding the account number.

Dept. Head Name (please print)	Phone No.

Department Head Signature

2/18/11 rev

UNIVERSITY OF Cincinnati

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Section IV – Employee Authorization

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing. YOU MAY REFUSE TO SIGN this authorization. HOWEVER, if you refuse you will not be permitted to participate in the Leave Donation Program. You have the right to revoke this authorization in writing at any time, except to the extent that the University of Cincinnati or its authorized representatives have taken action in reliance on it.

You may provide additional restrictions upon the use or disclosure of your personal health information not otherwise provided for below. The University of Cincinnati is not required to accept additional restrictions. However, the University will be bound by any additional restrictions it accepts. This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization by you, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of The Health Insurance Portability and Accountability Act of 1996, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of the University of Cincinnati, or (d) six years from the date this authorization was executed.

APPLICANT SHOULD CHECK ONLY ONE OF THE FOLLOWING TWO OPTIONS:

☐ Applicant authorizes his/her name, position, department and the fact that he/she has a serious medical condition to be advertised in the notice. By signing the space provided at the end of this Authorization, applicant's immediate family member authorizes the use or disclosure of his/her personal health information, including, the existence of such immediate family member's medical condition.

☐ Applicant does not want any notices posted requesting voluntary donations as he/she has personal knowledge of interested potential donor(s) and will notify the potential donors(s) when recipient eligibility is established.

I am aware of the University of Cincinnati policy to protect the voluntary nature of donations by keeping confidential the identities of leave donors. By submitting this application, I hereby waive any right of access provided by law (including the Privacy Act of 1974, 5USC 552a) to information or records concerning the persons who donate leave for my use in response to this application. I understand that there are no guarantees as to the number of hours of leave that will be donated, as participation in this program is strictly voluntary. Further, I and/or my immediate family member, are aware of and have read the University of Cincinnati Privacy Policy regarding personally identifiable health information. By signing this authorization I and/or my IFM acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipients and no longer protected by the University of Cincinnati Privacy Policy.

Signature of Applicant _____ Date _____

Signature of Immediate Family Member (if applicable) _____ Date _____