Donated Time Eligibility

Department:_____

(Form to be completed by Department Human Resources)

Please complete this checklist as a preliminary step prior to submitting your request to the Review Board. Once completed and approved by the Department must submit this form to the CEO Office for consideration.

Employee Name:_____ Dates of Medical leave:_____

Catastrophic Illness:_____

_____

PART I. EMPLOYEE CHECKLIST

Does any of the following apply to this employee: *(please circle the answer)*

Part-time, Extra-Help, or PSC employee	Yes	No
Formal discipline (for attendance) in the last 12 months	Yes	No
Currently on initial County probation	Yes	No
Received donated time in the last 12 months	Yes	No
Employee waived eligible SDI benefits	Yes	No
Currently on corrective action plan for attendance (excluding approved leave time or attendance issues related to qualifying injury or illness)	Yes	No

If any of the questions above were yes, the employee is not eligible for Donated Time.

Comments:_____

_____

_____

Employee Service Date: **Balances:VAC** **SICK** **COMP**

PART II. DEPARTMENT APPROVAL

Be sure to include the following along with this checklist:

- ❑ Copy of completed and approved Leave of Absence Request Form
- ❑ Copy of completed Employee/Physician Catastrophic Leave Form.

_____ _____

Department Head or Designee **Date**

Copies to: Medical File, Department HR and Employee's Manager

Review Board Use Only:

Approved:_____ Denied:_____

Reason:_____

_____

Review Board Representative:_____ Date:_____

EMPLOYEE/PHYSICIAN
CATASTROPHIC LEAVE APPLICATION FORM

Name: _____ Date:_____
Dept: _____ Contact number:_____

Current employment status:
- ❑ Working ____ hours per week
- ❑ Sick leave with compensation
- ❑ Leave without pay

Section to be completed by requesting employee:

Please state the reason for your request to use donated time. Include any information related to your catastrophic condition that may assist the review board.

Please provide the names and contact information for each physician treating your illness:
Name:
Address:
Phone:

Section to be completed by the requesting employee's physician:

The patient is:
- ❑ Permanently unable to complete a substantial portion of his/her job duties.
- ❑ Temporarily unable to complete a substantial portion of his/her job duties.

1. What is the employee's prognosis?

2. In your opinion will the employee be able to return to work? If so, please estimate a time frame.

3. Will work restrictions apply?

Physicians' signature_____ Date: _____
(A stamped signature will not be accepted)