Request for Annual Leave Donations
Serious Health Conditions

Represented Employees, UNR, MGT, SMG & HDS

Annual Leave donations are permissible pursuant to Salary Resolution 600 & 700 or applicable Memorandum of Understanding (MOU). To qualify for Annual Leave donations under a **Serious Health Condition** for self or a qualifying family member, the following conditions apply:

- The employee must have suffered a serious health condition as defined by the Family Medical Leave Act (FMLA) or California Family Rights Act (CFRA); or
- The employee requires time off work to care for an FMLA/CFRA qualifying family member (child, parent, grandparent, grandchild, sibling, spouse, or domestic partner) with a serious health condition; and
- The employee must have exhausted all paid leave hours (Annual, Vacation, Sick, Comp Time, Accrued Holiday, etc.)

Requests for donations should be submitted to your Department Personnel Representative as early as possible to allow for timely processing. Contact your Department Personnel Representative for biweekly processing deadlines.

Last Name: _____ First Name: _____ Employee ID: _____

Department: _____ Job Title: _____ Last Day Worked: _____

Is the leave for self or relative? ☐ Self ☐ Relative Relationship to Relative _____

By signing below, I understand that if I do not meet the Annual Leave Donation Program conditions, I will not be eligible to receive donated hours. Additionally, I understand that I must solicit for my own donations which, depending on date received, may not be applied until the following pay period. In no circumstance will retroactive donations be approved.

Employee Signature/Date: _____

PLEASE RETURN THIS COMPLETED FORM, ALONG WITH SUPPORTING MEDICAL DOCUMENTATION, TO YOUR DEPARTMENT HR REPRESENTATIVE

FOR USE BY DEPARTMENT HR REPRESENTATIVES

Please complete and submit a copy to Human Resources - Employee Benefits by email to HRALDonations@fresnocountyca.gov by 4:00 p.m. on the **first Friday** of the pay period (unless otherwise notified) in which donations are being requested.

Donations to begin PP: _____ Is employee integrating? ☐ Yes ☐ No

If integrating, check all that apply: ☐ Work Comp (OJI) ☐ SDI ☐ PFL ☐ PORAC

Leave Designated As:

☐ FMLA/CFRA/PDL Dates eligible: _____ Prior usage last 12 months (dates): _____

☐ OJI ☐ Approved ☐ Pending

☐ ADA/FEHA Interactive letter attached? ☐ Yes ☐ No If no, please explain:

Is employee on intermittent leave? ☐ Yes ☐ No Intermittent/reduced schedule: _____

Processed by: _____ Date to HR: _____

EMPLOYEE BENEFITS AUTHORIZATION

A/L balance as of: Date: _____ Balance: _____

Leave Type: ☐ Total Disability ☐ Intermittent Leave

Initial Donations Approved From: _____ Through: _____

☐ APPROVED ☐ DENIED Authorized By: Date: _____

Request for Annual Leave Donations
Catastrophic Illness or Injury

Represented Employees, UNR, MGT, SMG, HDS

Annual Leave donations are permissible pursuant to Salary Resolution 600 & 700 or applicable Memorandum of Understanding (MOU). To qualify for Annual Leave donations due to a **Catastrophic Illness or Injury** for self or qualifying relative, the recipient must meet the following conditions:

- Has an unexpected and/or unplanned illness or injury, that is not chronic in nature, that would likely result in an imminent threat to loss of life and/or limb and that requires immediate medical intervention (treatment, surgery and/or rehabilitation) and that temporarily prevents the employee from working while he/she receives said medical care/treatment; **OR**
- Has a spouse, dependent child, or dependent grandchild (legal guardianship is required) with a catastrophic illness or injury that is verifiable, incapacitating, and life threatening and is so serious in nature as to require extensive, long-term medical treatment, prolonged hospitalization, or an extended recovery period and requires the employee to be present to care for the family member; **AND**
- The employee must have exhausted all paid leave hours (e.g., Annual, Vacation, Sick, Comp Time, Accrued Holiday, etc.)

This request, including extensions, must be accompanied by the **County of Fresno Catastrophic Illness or Injury Medical Certification Form** (page 2) completed by the treating physician. Requests for donations should be submitted to your Department Personnel Representative as early as possible to allow for timely processing. Contact your Department Personnel Representative for biweekly processing deadlines.

Last Name: _____ First Name: _____ Employee ID: _____

Department: _____ Job Title: _____ Last Day Worked: _____

Is the leave for self or relative? ☐ Self ☐ Relative Relationship to Relative _____

By signing below, I understand that if I do not meet the Annual Leave Donation Program conditions, I will not be eligible to receive donated hours. Additionally, I understand that I must solicit for my own donations which, depending on date received, may not be applied until the following pay period. In no circumstance will retroactive donations be approved.

Employee Signature/Date: _____

PLEASE RETURN THIS COMPLETED FORM, ALONG WITH SUPPORTING MEDICAL DOCUMENTATION, TO YOUR DEPARTMENT HR REPRESENTATIVE

FOR USE BY DEPARTMENT HR REPRESENTATIVES

Please complete and submit a copy to Human Resources - Employee Benefits by email to HRALDonations@fresnocountyca.gov by 4:00 p.m. on the first Friday of the pay period (unless otherwise notified) in which donations are being requested.

Donations to begin PP: _____ Is employee integrating? ☐ Yes ☐ No

If integrating, check all that apply: ☐ Work Comp (OJI) ☐ SDI ☐ PFL ☐ PORAC

Leave Designated As:

☐ FMLA/CFRA/PDL Dates eligible: _____ Prior usage last 12 months (dates): _____

☐ OJI ☐ Approved ☐ Pending

☐ ADA/FEHA Interactive letter attached? ☐ Yes ☐ No If no, please explain:

Is employee on intermittent leave? ☐ Yes ☐ No Intermittent/reduced schedule: _____

Processed by: _____ Date to HR: _____

EMPLOYEE BENEFITS AUTHORIZATION

A/L balance as of: Date: _____ Balance: _____

Leave Type: ☐ Total Disability ☐ Intermittent Leave

Initial Donations Approved From: _____ Through: _____

☐ APPROVED ☐ DENIED Authorized By: Date: _____

Catastrophic Illness or Injury
Medical Certification Form

Represented Employees, UNR, MGT, SMG, HDS

Dear Health Care Provider:

To determine employee eligibility for annual leave donations through the Fresno County catastrophic injury or illness program, please complete the Health Care Provider Section on this form. If you have any questions, please call Fresno County Human Resources at 600-1820.

EMPLOYEE SECTION

EMPLOYEE NAME | **PATIENT NAME (IF NOT EMPLOYEE)** | **PATIENT RELATIONSHIP TO EMPLOYEE**

REQUESTED LEAVE BEGIN DATE | **ANTICIPATED LEAVE END DATE**

☐ **If leave is for my own catastrophic illness or injury, by checking the box to the left, I authorize my health care provider to share my diagnosis at the bottom of this page.**

_____
Employee Signature / Date

HEALTH CARE PROVIDER SECTION

The County of Fresno's definition of a catastrophic illness or injury is described below. Please indicate if the leave is for the employee or their qualifying family member by checking the appropriate box:

Catastrophic Leave is for:

☐ **Employee** - A catastrophic illness or injury that is covered by this section is defined as an unexpected and/or unplanned illness or injury, that is not chronic in nature, that would likely result in an imminent threat to loss of life and/or limb and that requires immediate medical intervention (treatment, surgery and/or rehabilitation) and that temporarily prevents the employee from working while he/she receives said medical care/treatment.

☐ **Family Member - The employee's spouse, domestic partner, parent, child, or dependent grandchild** must have a catastrophic illness or injury that is verifiable, incapacitating, and life threatening and is so serious in nature as to require extensive, long-term medical treatment, prolonged hospitalization, or an extended recovery period and requires the employee to be present to care for the family member.

Please select the option the employee's catastrophic illness or injury relates to (if the box above the employee's signature line is checked please provide the diagnosis):

☐ **INVASIVE CANCER**
☐ **DEBILITATING STROKE OR HEART ATTACK MAJOR ORGAN TRANSPLANT**
☐ **MAJOR ORGAN TRANSPLANT**
☐ **SEVERE ACCIDENT/INJURY**
☐ **OTHER (please specify):** _____

Printed Name of Health Care Provider: _____

Signature of Health Care Provider: _____

Medical Health Care Specialty: _____

Date: _____

Phone: _____

Place Stamp Here

Agreement to Donate Annual Leave

Represented Employees, UNR, MGT, SMG & HDS

Pursuant to Salary Resolution Sections 600 & 700, I request to donate Annual Leave hours as specified below. If approved by the Department of Human Resources, I understand that this donation is unconditional and irrevocable, and shall be treated as though it had been earned by the **recipient** at their regular rate of pay.

Note: A maximum of 40 hours* per payroll year may be donated by the donor, and only if after the donation, the donor has a remaining balance of 120 hours of Annual leave/Sick/Vacation. Employees who have given official notification of their intent to separate from County employment **may not** donate under any circumstance.

*Donor **may** be approved for waiver of the 40-hr limitation for catastrophic illness or injury pursuant to Salary Resolution Sec 618.4.

Recipient's Name: _____ **Recipient's Department:** _____

Donor Name: _____ Donor Employee ID: _____

Donor Department: _____ Donor Work Phone: _____

Have you previously donated to a County employee in the current payroll year? ☐ Yes ☐ No

If yes, hours you donated: _____

In the section below, indicate your current balance and the number of hours you wish to donate

	Current Balance	Hours Donated
Annual Leave I/II/III/IV (AL/AL04)		
Sick Leave I/II (SV02)		
Vacation Leave I/II (SV02)		
Time Off Bank (TOB)		

Donor Signature/Date: _____

Witness Signature (other than recipient)/Date: _____

Please return this form to the recipient's HR representative

DEPARTMENT REPRESENTATIVE SECTION

Complete and forward a copy to Human Resources – Employee Benefits by email to HRALDonations@fresnocountyca.gov by no later than 12 pm on the 2nd Wed. of a pay period in which donations are to be applied, unless otherwise notified due to closures.

Recipient: ID #: _____ AL Bal: _____ as of PPE: _____

Integrating? ☐ Yes, Work Comp (OJI) ☐ Yes, Other ☐ No

Donor Info:

Donor maintains at least 120 hours after this request is applied? ☐ Yes ☐ No
(If no, the donor is not eligible to donate hours)

Processed By: Date to HR:

EMPLOYEE BENEFITS AUTHORIZATION (HR-Benefits will reply to the department with approval via e-mail)

Benefits Representative: Date of Approval: