RECIPIENT AFFIDAVIT
DONATED LEAVE PROGRAM
COUNTY OF MONMOUTH

Employee Statement

Name: _____Employee No: _____Date:_____

Department: _____Title:_____Telephone:_____

I have read the policy and procedures regarding the donated leave program and I consent to participation in this program.

I hereby request approval to participate in the donated leave program.

I have attached a doctor's certification to this affidavit attesting to the nature of the catastrophic health condition (which requires absence from work for continuous period of 60 or more working days) as follows:

- ☐ My own catastrophic health condition or injury
- ☐ To provide care to a member of my immediate family who is suffering from a catastrophic health condition
- ☐ Due to the donation of an organ (which shall include, for example, the donation of bone marrow)

I have not directly or indirectly intimidated threatened or coerced, or promised any benefit to any employee for the purpose of obtaining donated leave.

I have not interfered with any right which another employee may have with respect to contributing, receiving or using paid leave under this program.

I understand that I cannot receive other payments such as workers' compensation, short-term disability compensation provided through the County of Monmouth insurance programs for the same period that I am paid wages from donated sick and/or vacation leave or while using any of my own leave.

I understand that under the short-term disability compensation provided through the County of Monmouth insurance programs require that I use all of the donated sick and/or vacation leave before benefits can be paid under the programs.

I ☐ authorize ☐ do not authorize my department to post notice of my eligibility in my department for potential leave donations.

I ☐ authorize ☐ do not authorize the Human Resources Department to post notice of my eligibility to all Monmouth County departments for potential leave donations.

MY SIGNATURE CERTIFIES THE INFORMATION IN THIS STATEMENT IS TRUE AND CORRECT

Employee Signature: _____ Date: _____

Human Resources Department Statement

☐ Medical Documentation Received ☐ Other:_____

The above employee ☐ does ☐ does not meet the criteria for an qualifying catastrophic event

Previous Catastrophic Leave Dates (if applicable): _____

Has the employee had any discipline action in the last 2 years? ☐ Yes ☐ No ☐ Other_____

Human Resources Department Signature: _____ Date: _____

Department Statement

Last day worked:_____

As of the end of the last pay period ending _____ the employee's leave balances are as follows:

Vacation leave (days/hours) _____ Sick leave (days/hours) _____

Personal leave (days/hours) _____ Other leave (days/hours)_____

Department Head review: Approved Denied

(If denied reason must be given):_____

Department Head Signature: _____ Date: _____