REQUEST FOR DONATED LEAVE
COUNTY OF MONMOUTH

Employee Statement

Name: _____Employee No: _____Date:_____

Department: _____Title:_____Telephone:_____

I am requesting donated leave **beginning** _____ and **ending** _____ for the following reason:

- ☐ 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)

Have you received Catastrophic Leave before as a Monmouth County Employee? ☐ Yes ☐ No

Medical documentation describing the nature of the catastrophic health condition from the physician or other appropriate health care provider showing the diagnosis, prognosis, and duration of illness must be attached:

_____

_____Additional sheet(s) attached: Yes No

Date condition began: _____ Date condition is expected to end: _____

Name of physician who will verify the condition: _____ Telephone No: _____

Address (city, state, zip code): _____

Type of practice: _____

Name of individual completing this request (If applying on behalf of the employee): _____

Relationship to employee: _____Telephone: _____

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

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) _____

Department Head review: Approved Denied

(If denied reason must be given):_____

Department Head Signature: _____ Date: _____