**Request to Receive**

**Leave Donations**

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| --- |
| **PART I: TO BE COMPLETED BY RECIPIENT** |
| Recipient’s (your) Name | Personnel Number |
|       |       |
| Agency | Work Location/Building |
|       |       |
| **For absences due to a family member, state the following:** |
| Family Member’s Name | Relationship to Recipient |
|       |       |
| **Recipient Statements:** |
| [ ]  A *Serious Health Condition Certification* form and *Medical Condition Certification to Receive Leave Donations* form are attached.[ ]  Donated leave will be used to cover unpaid absences due to my own or my family member’s catastrophic/severe injury or illness.  |
| [ ]  If my request is approved, my human resources office is authorized to solicit leave donations on my behalf from employees within my agency. The catastrophic/severe injury or illness will not be divulged. [ ]  I authorize the Office of Administration to solicit leave donations from employees in other agencies under the Governor’s jurisdiction if needed. The catastrophic/severe illness or injury will not be divulged.[ ]  My relatives below are commonwealth employees willing to donate leave and should be solicited. I understand they must submit a [***Request to Donate Leave Form***](https://www.hrm.oa.pa.gov/Leave/forms/Documents/leave-donation-request.pdf) to the person listed on the solicitation email.

|  |  |
| --- | --- |
| **Relative’s Name** | **Relative’s Agency** |
|       |       |
|       |       |
|       |       |

 |
| Recipient’s Signature | Date |
|  |       |
| **PART II: TO BE COMPLETED BY HUMAN RESOURCE OFFICE** |
| [ ]  Recipient is a permanent employee.[ ]  The absences were not due to a work-related injury or illness.[ ]  In the past six-month period, the recipient **has not**: ● ***been placed on a written leave restriction***● ***received a written reprimand related to attendance***● ***received a suspension related to attendance***[ ]  The recipient used all accrued and all anticipated leave for the current leave calendar year, per the applicable labor agreement. |
| **I recommend:** | **Begin Date** | **End Date** | **Total Days** |  |
|  [ ]  Approval [ ]  Disapproval |  |  |  |  |
|  |
| Human Resource Director/Designee Signature | Date |
|  |  |
| **PART III: TO BE COMPLETED BY OFFICE OF ADMINISTRATION** |
| [ ]  Approved [ ]  Disapproved |
|  | **Begin Date** | **End Date** | **Total Days** |  Reason: |
|  |  |  |  |  |
|  |
| Secretary of Administration/Designee Signature | Date |
|  |  |