**Request to Receive**

**Leave Donations Across Agencies**

|  |
| --- |
| **PART I: TO BE COMPLETED BY RECIPIENT** |
| Recipient (your) Name | Personnel Number |
|       |       |
| Agency | Work Location |
|       |       |
| Building | Address of Building |
|       |       |
| **For absences due to a family member, state the following:** |
| Family Member’s Name | Relationship to Recipient |
|       |       |
| [ ]  I have been approved to receive leave donation by the Office of Administration for my or my family member’s catastrophic/severe injury or illness. To date, I have not received sufficient donations to cover my absence and need additional donations.[ ]  The donated leave will be used to cover absences due to my (or my family member’s)  |   |
|  catastrophic/severe injury or illness | **Begin Date** | **End Date** |  |
|  |       |       |  |
| [ ]  An exception to the reasonable geographic distance limitation will be allowed for relatives who wish to make donations. The following relatives are willing to donate leave. I understand that donations from relatives will be accepted first and that they must submit a *Request to Donate Leave* form to the Office of Administration, Absence and Safety Division via ra-oaleave@pa.gov. |
|  | **Relative’s Name** | **Relative’s Agency** |  |
| 1. |       |       |  |
| 2. |       |       |  |
| 3. |       |       |  |
| [ ]  I authorize the Office of Administration to announce to employees outside of my agency that I or my family member have a catastrophic/severe injury or illness and donations may be accepted across agencies within a reasonable geographical distance from my work location. The nature of the catastrophic/severe injury or illness will not be divulged. |
| Recipient’s Signature | Date |
|  |       |
| **PART II: TO BE COMPLETED BY HUMAN RESOURCE OFFICE** |
| [ ]  **Two** requests for donated leave were announced to employees within the agency, but insufficient donations were requested. |
|  | **Total Days OA Approved** | **Donations Received to Date** | **Donations Needed** |  |
|  |  |  |  |  |
|  |
| Agency Time Advisor or FMLA/SPF Coordinator Signature | Date |
|  |  |
| **PART III: TO BE COMPLETED BY OFFICE OF ADMINISTRATION** |
| [ ]  Relatives identified above were notified.  | **1st Announcement Sent** | **2nd Announcement Sent** |
| [ ]  A broadcast message to **all** prospective donors was sent. |  |  |
| [ ]  Disapproved |
|  Reason: |
| Secretary of Administration/Designee Signature | Date |
|  |  |