**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](mailto: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 | | | | | |
|  | | | | | | | |  | | | | | |