DONATED (SHARED) LEAVE PROGRAM

Policy Statement

Georgia Southwestern State University is authorized to establish policies through which employees may contribute on a voluntary basis unused sick leave for possible use by another GSW employee who is experiencing a catastrophic illness or injury and who has used all accumulated paid leave.

Reason for Policy

The purpose of the Shared Sick Leave Program is to provide a means for Georgia Southwestern State University employees to donate paid sick leave to a leave pool to be used by fellow employees who are eligible for and require leave while experiencing a life-threatening or emergency medical condition as defined, and which has caused, or is likely to cause, the employee to take leave without pay.

Contacts

Contact	Phone	e-mail/URL
Vice Chancellor for Human Resources	404-463-0543	wayne.guthrie@usg.edu
GSW Chief Human Resources Officer	229-931-2000	gena.wilson@gsw.edu

Definitions

These definitions apply to the terms as they are used in this policy:

- **Employee** means any employee of Georgia Southwestern State University who earns or accrues sick leave as a benefit of his/her employment by the University, including part-time employees, whose leave transfer amounts will be pro-rated based on their percent of time worked at Georgia Southwestern during either the past twelve months or their entire time in service at Georgia Southwestern State University, whichever term is shorter.
- **Physician/Medical Provider** must be licensed by his/her respective state.
- **Leave donor** is an employee that makes a voluntary, written request for the irrevocable transfer of sick leave to a GSW employee. Once leave has been transferred, it may not be used by the donor for any other benefit purposes.
- **Leave recipient** Means a current employee who has completed the employment provisional period and for whom the Georgia Southwestern State University Shared Leave Certification Committee has approved an application to receive donated leave. The recipient may use Shared Leave for any purpose authorized under the Board of Regents Program Manual Section 802.0802 which meets the definition of life- threatening or emergency medical condition as described below.

- **Immediate Family** Consistent with the FMLA guidelines, immediate family includes: mother, father, husband, wife, and child.

  A Child Includes: A biological, adopted, or foster child; a stepchild; a legal ward; or a person for whom the employee has (or had during the person's youth) daily responsibility to care and financially support and who is either under 19 years of age or is incapable of self-care because of a physical or mental disability.

  A Parent Includes: A biological (or in loco parentis) "parent".

  A Spouse Includes: Husband or wife as defined or recognized under state law for purposes of marriage.

- **Life-threatening or emergency medical condition** means a health condition involving a serious, extreme, or life-threatening illness, injury, impairment, or condition that is likely to require an employee's absence from duty for a period of time longer than the amount of sick and annual leave available to the employee, and the health condition is such that it is not medically appropriate for the employee to delay the absence in order to accrue additional sick or annual leave prior to the absence. Some examples of such conditions include: advanced or rapidly growing cancers, acute life-threatening illnesses, chronic life-threatening conditions in need of immediate care, life-threatening infections, severe injuries arising from automobile or other serious accidents and severe or life-threatening conditions involving failure of bodily organs or systems (e.g., heart attack). The absence may be continuous, as in hospitalization following surgery or an accident, or intermittent, as in periodic absences for chemotherapy or other procedures.
- **Catastrophic personal injury or illness** is a severe condition or combination of conditions affecting the mental or physical health of an employee or immediate family and has had a major impact on life functions.

Donation of Leave

Employees will be given the opportunity to donate a specified number of hours of sick leave (in eight (8) hour increments) from their sick leave accounts to a qualified employee. An employee who donates leave must retain a combined total of forty (40) hours of leave in his/her own sick leave accounts (pro-rated for part-time employees). No employee shall be denied an opportunity to donate sick leave hours if the program criteria are met.

A participating employee shall not be allowed to donate any unused or unpaid sick leave from the employee's personal account at the time of separation from Georgia Southwestern State University, including retirement.

The employee will continue to accrue sick leave during their absence as long as they are paid at least one half of a monthly salary.

Eligibility for Benefit:

In order to be eligible to receive Shared Leave, the employee must:

- have completed the initial provisional period of employment, and
- provide certification from a licensed physician/health provider of a life-threatening or emergency medical condition, and
- have exhausted all sick and annual leave (or provide credible medical evidence that he or she will have exhausted all sick and annual leave before the medical condition is resolved).

Ineligible Employees:

a. Those employed with less than one-half the standard workload, irregular, seasonal or temporary employment for a definite period of less than four and one-half months during an academic year are ineligible to participate.
b. Student employees are not eligible if student status is a required condition of their employment.
c. Retirees are not eligible to participate.
d. Employees on leave without pay are not eligible unless their leave without pay status is a result of depleting accrued paid leave because of the qualifying illness or injury. If an employee has returned from leave without pay, the employee is ineligible until he or she completes a minimum of 30 active workdays.
e. Employees with a work-related catastrophic illness or injury that is covered by Workers' Compensation Insurance are not eligible to withdraw time from the leave pool.

Leave Committee:

The committee shall consist of Human Resources employees.

Application of Benefits:

An eligible employee may request donated leave by completing the *Donated Leave Request Form*, obtaining a completed *Physician's Certification Form* and submitting these documents to Human Resources. If the employee is not capable of making application on his or her own behalf, a personal representative, having documented power of attorney for the employee, may make written application on behalf of the employee by completing the *Donated Leave Request Form*, obtaining a completed *Physician's Certification Form* and submitting these documents to Human Resources.

A potential leave recipient may request up to 160 hours of Shared Leave at one time, and may make up to two additional requests for Shared Leave within a calendar year, for a maximum total of 480 hours per year within a five (5) year period. The requests may be consecutive.

Confidentiality

Any medical information provided to the Shared Leave Certification Committee will remain confidential **and** will not be shared with anyone. *Potential leave recipients, their representatives and Shared leave committee members must refrain from using institutional e-mail to solicit leave by revealing a medical condition, as e-mailing of medical information may violate HIPAA privacy guidelines.*

Approval Process

If any committee member(s) is unavailable to perform the functions of the committee due to illness, vacation, or other reason, or is unable provide a timely decision for any given applicant, the Chief Human Resources Officer, will choose a designee to serve as substitute ad hoc member(s) of the committee.

The committee's decision to approve or disapprove a request for Shared Leave will be by simple majority vote and may be the result of communication by email, telephone, or other means in lieu of meeting together in one location.

If the request is approved, the Shared Leave Committee will notify the notify the applicant (or the personal representative who applied on behalf of the employee) within five (5) working days after the date the completed request for Shared Leave is received (or the date that the institution makes changes to these policies or procedures, if that date is later) that:

- the request has been approved; and
- if the employee has entered the status of leave without pay, the approved Shared Leave may be substituted retroactively to cover the period of leave without pay.
- Or the request has been denied; and the reason for the denial

Appeal

Requests which have been denied may be appealed in writing to Georgia Southwestern State Universities Human Resources office.

Responsibilities

The responsibilities each party has in connection with the Policy on Donated Leave are:

Party	Responsibility
Vice Chancellor for Human Resources, USG	Provide guidance to institution human resources officers on appropriate application of the donated leave policy, monitor campus practices for compliance.
GSW Chief Human Resources Officer	Ensure appropriate utilization of the GSW donated leave policy, including program enrollment and ethical application of the policy, ensure compliance with applicable laws.

Forms

- Donated Leave Membership Form
- Donated Leave Request Form
- Physician’s Certification Form

Appendices - Frequently Asked Question’s

Who is eligible to request Shared Leave?

An employee who has completed the Board program provisional period and has a life-threatening or emergency medical condition and has exhausted, or will exhaust his/her personal leave time

How will I know that I have received Shared Leave?

You will be notified by Human Resources via written documentation.

Will an affected employee continue to accrue sick and annual during the time missed from work?

Yes, the employee will accrue leave based on their current status. Accrued leave will be applied to the absence before Shared Leave is applied.

How much leave may be requested?

You may request up to 160 hours of leave per application (pro-rated for part-time employees) up to three (3) times in a calendar year for a maximum of 480 for a five (5) year period.

Who is eligible to donate leave?

Any benefit eligible employee who has completed their six (6) month provisional period.

How much leave may I donate?

You may donate leave in eight hour (8, 16, 24, etc) increments but must maintain at least forty (40) hours of personal sick leave.

What if I change my mind about donating leave?

Donations are irrevocable.

Can I donate leave upon my leaving Georgia Southwestern State University?

Leave cannot be donated upon termination.

Donated Leave Program
Recipient Affidavit
Donated Leave Request Form

I request a leave award from the Donated Leave Program under the terms specified in the Georgia Southwestern program description, and with the understanding that the specific nature of my illness will be kept confidential.

______________________________ ____________________
Name of Recipient (Print) Today's Date

______________________________ ____________________ __________________
Department Email Cell Phone #

______________________________ _______________________________________
Date Medical Condition Began Date Medical Condition Ended
(or is expected to end)

I have not directly or indirectly solicited donations of sick leave time from other Georgia Southwestern State University employees independently. I have not interfered with any right which another employee may have with respect to contributing, receiving or using sick leave under this program.

I am submitting herewith medical verification (Physician's Certification Form) which confirms a life-threatening or emergency medical condition as described in the Georgia Southwestern State University Donated Leave Program policy.

I certify that the above statements are true and complete to the best of my knowledge. If I am acting on behalf of the employee recipient, I am providing documentation as having Power of Attorney with this form.

____ _______________
Signature of Recipient or Authorized Recipient Representative Date

INSTRUCTIONS: Please forward this Recipient Affidavit and supporting documentation to the HR-Benefits Office, 800 Georgia Southwestern State University Drive Americus, GA 31709
Mark "confidential" and c/o the "Donated Leave Certification Committee".

Donated Leave Program
LEAVE DONATION FORM

____
Full Name of Donor (Print)

________________________________ ________________________________
Department Email

________________________________ ________________________________
Cell Phone Number Date of Hire

I wish to donate _________ hours of sick leave (8 hour minimum and 40 hour maximum) to be used as part of the Donated Leave Program. This is a one-time donation on behalf of a specific employee, _____________________________.

An employee who donates leave must retain a combined total of 40 hours of leave in his/her own annual and sick leave accounts (pro-rated for part-time employees). For example, if you are a half-time employee (.50 for staff or .38 for faculty), a combined total of 20 hours annual or sick leave must be retained.

I agree that my donation is strictly voluntary. I agree that the transfer hours have already been accrued. I agree that after my leave donation has been charged against my balance, it is irrevocable and **cannot be withdrawn**.

____ ___________________
Signature of Donor Date

Donated Leave Program
PHYSICIANS' CERTIFICATION FORM

Part A. To Be Completed by the Employee

________________________ ______________________ __________________

FOR USE BY THE DONATED LEAVE CERTIFICATION COMMITTEE

___________ Transfer approved ____________ Transfer not approved

This is to advise you that your request to donate sick leave time cannot be accepted due to the following reason(s):
____
____
____

____ ________________
Signature of Authorizing Official Date

Employee Name Cell Phone Number Home Phone Number

______________ ________________ _______ _____ _____
Employee Department Home Address City State Zip Code

___________________ ________________
Patient Name (If applicable) Relationship (If applicable)

Part B. To Be Completed by the Physician

1. In your opinion does the employee/patient meet the "Life-threatening or emergency medical

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condition" definition as described above? Yes or No (Check One) (Attach additional sheet if more space is needed).

2. Date patient was first unable to work: ______________________________

3. Diagnosis description: ______________________________

4. Method of treatment: ______________________________

5. Has the patient been hospital confined? Yes or No (Check One) If yes, provide hospital name and admittance date: ______________________________

6. Prognosis: (probable duration of condition) ______________________________

7. When could patient resume work? (List any restrictions to regular duty) ____________
____

Physician's Name: __________________ __________________
(Please Print) Specialization

Address: ______________________________

Physician's Signature: ______________________ Date: ______________
(Please do not use Stamp or Designee Signature)

Donated Leave Program
PHYSICIANS' CERTIFICATION FORM Continued

Part C. To Be Completed by the Employee or Person acting on behalf of the Employee

I understand that the information requested on this Physician's Certification of Emergency or Life Threatening Medical Condition Form is for the use of determining my eligibility to participate in the Donated Leave Program at Georgia Southwestern State University. Failure to provide all the requested information will result in my request not being processed or approved by the Donated Leave Certification Committee. Further, I am aware that any medical information provided will remain confidential and will not be shared with other employees in Human Resources, my Department or elsewhere within the University. If I am acting on behalf of the employee patient, *I am providing documentation as having Power of Attorney with this form.*

____ _________________________
Employee Patient Signature Date

____ _________________________
Print Name of Person acting on behalf of the Employee Patient Date

____ _________________________
Signature of person acting on behalf of the Employee Patient Date
PCMC