Leave Sharing Bank

State Classified
HUMAN RESOURCES

The Leave Sharing Program was established to provide partial income protection to eligible state classified employees who are absent from work for a prolonged period of time, but who have inadequate paid time-off accumulated (annual leave, sick leave, compensatory time or accrued holiday time) to cover the absences. You may reference the University's Leave Sharing Program Policy for State Classified Personnel on the Office of Policy and Compliance website for complete program details (eligibility exceptions, program definitions, hour usage applicable to each qualifying reason and the program application process). The Leave Sharing Program application is located on the Human Resources website at hrs.colostate.edu.

Part I: Employee Information

Name:	Employee ID:
Address:	Home Phone: Work Phone:
City: Zip:	Date of Birth:
Job Title:	Department Name:
Date of Hire:	Gross Monthly Salary:

Part II: Leave Sharing Program Eligibility

Continuous Employment

You must have completed at least one (1) year of **continuous** employment in a state classified position **at the University**.

☐ **YES** I have completed one (1) year of continuous employment in a state classified position at the University.

☐ **NO** I have not completed one (1) year of continuous employment in a state classified position at the University.
*(If **NO**, you are not eligible to apply for the Leave Sharing Program, please do not submit this application.)*

Leave Exhaustion

Depending on the scenario applied for, the exhaustion of all annual leave, sick leave, compensatory time or accrued holiday time, may be required. Leave sharing hours may only be used when you have inadequate paid time-off accumulated to cover the absence or if you are approved for a leave sharing scenario that does not require the exhaustion of leave. *Please review the requirements for each leave sharing scenario regarding the exhaustion of leave.*

☐ **YES** I have exhausted all leave, or will exhaust all leave, if applicable

☐ **NO** I have not exhausted all leave and I have enough accumulated leave to cover the absence
*(If **NO**, you are not eligible to apply for the Leave Sharing Program, please do not submit this application.)*

Hour Usage: The 30-calendar day benefit waiting period prior to Short-Term Disability (STD) income replacement will be covered if your Leave Sharing Program application is approved; regardless of whether the STD claim is approved or denied. Leave sharing hours **may not be used** to make an employee's compensation "whole", when receiving STD or worker's compensation income replacement benefits.

Ancillary Benefits

Complete all that are applicable, if you are applying for your **own medical condition.**		**- Human Resources Use Only -**	
☐ Family Medical Leave (FMLA) (Medical Certification required)	☐ FMLA Designated	Date Approved: ____/____/____	☐ Denied
☐ Long Term Disability (LTD)	☐ Applied	Date Approved: ____/____/____	☐ Denied
☐ PERA Disability Retirement	☐ Applied	Date Approved:____/____/____	☐ Denied
☐ Short Term Disability (STD)	☐ Applied	Date Approved:____/____/____	☐ Denied
☐ Worker's Compensation	☐ Applied	Date Approved:____/____/____	☐ Denied
☐ Not Applicable			

Part III: Qualifying Leave Sharing Situations

Leave sharing hours are only available after the employee has exhausted all annual leave, sick leave, compensatory time or accrued holiday time.

Scenario #1

(Please complete only **ONE** of the Leave Sharing scenarios)

Employee or the employee's immediate family member's condition which **Poses a Direct Threat to Life** or **Non-Life Threatening** catastrophic illness or injury (certified by a licensed physician)

☐ **Poses a Direct Threat to Life** such as a catastrophic life-threatening health condition. Time-off work **does not** need to be 30 or more continuous days to qualify, but must be life threatening.

Examples: Most major and emergency life-threatening conditions such as aortic aneurysm, cardiac arrest, heart attack, meningitis, sepsis, salmonella, head trauma, hyperthermia, spinal injury, renal failure, diabetic coma, ectopic pregnancy, pre-eclampsia, placental abruption, asphyxia, pulmonary embolism, respiratory failure, serious mental illness requiring inpatient care, injuries caused by serious accidents suffered outside of work or any other condition that could lead to the loss of life.

☐ **Non-Life Threatening** catastrophic illness or injury resulting in a period of incapacity of 30 or more continuous days of absence from work. Time-off work **does need** to be at least 30 continuous days of absence as certified by a physician.

Examples: Illness and injury resulting in 30 consecutive calendar days or more beginning with or without outpatient or inpatient surgery, such as serious chronic medical conditions (e.g., hypertension, arthritis, rheumatoid arthritis, severe asthma, orthopedic impairments, degenerative discs, diabetes, osteoporosis, bipolar mood disorder, schizophrenia, Crohn's disease, epilepsy, multiple sclerosis, Parkinson's disease, ulcerative colitis, etc.) or outpatient surgery and extensive therapy.

I am requesting Leave Sharing assistance for:

☐ **Myself;** OR

☐ because of an **Immediate Family Member***-Relationship to Employee ☐ Spouse ☐ Child - Age_____ ☐ Parent ☐ Other_____

**Immediate Family Member - An employee's child who is under the age of 18 or an adult child incapable of self-care, parent, spouse, legal dependent, or a person in the household for whom the employee is the primary caregiver. Documentation of the familial or caregiver relationship may be required.*

Hours Requested

Required

Full-Time employees may request up to **176 hours**
(Prorated for part-time)

Requested Leave Sharing Hours

Indicate the number of hours requested by using the worksheet below. ***If you need assistance in determining the number of hours to request, please contact your department personnel/payroll coordinator or Human Resources.*** The 30-calendar day waiting period for STD may be covered. Leave bank hours are not covered beyond the waiting period.

Last Day Worked:_____ Date ALL Accumulated Paid Leave is Exhausted: _____

STD Waiting Period: Date of Disability + 29 Calendar Days:_____

_____ → _____ = _____ x _____ = _____

Date Paid Leave Exhausted | End of STD Waiting Period | Days | Hours | Total Hours Requested

Physician's Certification

Your licensed physician must clearly document how your situation qualifies under the Leave Sharing Program rules to be reviewed for eligibility.

Patient's Name:_____ ☐ Employee ☐ Immediate Family Member

Medical Information

Primary and other related diagnosis: _____ Diagnosis Code(s):_____

Describe relevant medical facts related to the condition for which the patient needs care (e.g., symptoms, or any regimen of continuing treatment, therapy, follow-up visits, etc.):

_____

_____

Select the ONE category that best characterizes the patient's medical condition:

☐ **Poses a Direct Threat to Life** (catastrophic life-threatening health condition, does not need to be 30 or more continuous days.)

☐ **Non-Life Threatening** (catastrophic illness or injury, resulting in a period of incapacity of 30 or more continuous days.)

What is the duration of incapacity of the patient's condition: From_____/_____/_____ To _____/_____/_____

Is the patient unable to perform any of his/her job functions due to the condition: ☐ Yes ☐ No

If **Yes**, please describe job related limitations:_____

Immediate family member: What is the type and frequency of care that is medically necessary (e.g., daily, weekly, monthly, etc.)_____

_____

Physician:_____ Type of Practice/Medical Specialty:_____

(Print Name)

Address:_____ City_____ State_____ Zip_____ Phone (_____)_____

Physician Signature: **Date:**

I hereby certify that the medical information contained herein is true and accurate.

Part III: Qualifying Leave Sharing Situations

Leave sharing hours are only available after the employee has exhausted all annual leave, sick leave, compensatory time or accrued holiday time.

Scenario #2

(Please complete only **ONE** of the Leave Sharing scenarios)

Immediate Family Member's Incapacity

(See Scenario#1 for Family Member's Serious Medical Hardship or Catastrophic Illness or Injury)

☐ **Eligible Immediate Family Member's Incapacity** - Substantial limitations in performing activities of daily living which could be performed prior to illness/injury.

(Substantial limitation in seeing, speaking, hearing, breathing, sitting, standing, walking, lifting, performing cognitive tasks, feeding, bathing, dressing or grooming.

I am requesting Leave Sharing assistance for:

☐ **Immediate Family Member*** - Relationship to Employee ☐ Spouse ☐ Child - Age_____ ☐ Parent ☐ Other _____

- **Immediate Family Member - An employee's child who is under the age of 18 or an adult child incapable of self-care, parent, spouse, legal dependent, or a person in the household for whom the employee is the primary caregiver. Documentation of the familial or caregiver relationship may be required.*

Hours Requested
Required

Full-Time employees may request up to **176 hours**
(Prorated for part-time)

Requested Leave Sharing Hours
(Immediate Family Member's Incapacity)

Indicate the number of hours requested by using the worksheet below. ***If you need assistance in determining the number of hours to request, please contact your department personnel/payroll coordinator or Human Resources.*** Leave sharing hours may only be used when the employee has inadequate paid time-off accumulated to cover the absence.

Last Day Worked:_____

Date ALL Accumulated Paid Leave is Exhausted: _____

Difference Between _____ → _____ = _____ x _____ = _____

Date Paid Leave Exhausted | End of Duration of Condition | Days | Hours | Total Hours Requested

Physician's Certification

Your licensed physician must clearly document how your situation qualifies under the Leave Sharing Program rules, to be reviewed for eligibility.

Patient's Name:_____

Patient's serious medical hardship or catastrophic illness or injury preventing the patient from performing Activities of Daily Living (ADLs)?

_____
Patient's medical condition (diagnostic code & name)

If the employee is required to provide care for the family member, what is the type and frequency of care?

Activities of Daily Living	Frequency of Care			
☐ Feeding	☐ Daily	☐ Weekly	☐ Monthly	☐ Other_____
☐ Bathing	☐ Daily	☐ Weekly	☐ Monthly	☐ Other_____
☐ Dressing	☐ Daily	☐ Weekly	☐ Monthly	☐ Other_____
☐ Grooming	☐ Daily	☐ Weekly	☐ Monthly	☐ Other_____
☐ Other_____	☐ Daily	☐ Weekly	☐ Monthly	☐ Other_____

Explain why such care is medically necessary:_____

_____

Physician:_____ Type of Practice/Medical Specialty:_____
(Print Name)

Address:_____ City_____ State_____ Zip_____ Phone (_____)_____

Physician Signature: **Date:**

I hereby certify that the medical information contained herein is true and accurate.

Part III: Qualifying Leave Sharing Situations

Scenario #3

(Please complete only **ONE** of the Leave Sharing scenarios)

A Catastrophic Event or Emergency affecting the Employee's Residence

☐ **A Catastrophic Event or Emergency affecting the Employee's Residence** (Affecting one employee's residence) - A wildfire, flood, tornado, or other natural disaster, or accidental event such as a fire or natural gas explosion, which results in a loss of life or substantial loss or complete destruction of the employee's residence, is also eligible to apply for leave sharing hours.

OR

☐ **A Catastrophic Event or Emergency affecting multiple Employees' Residences -** Should a catastrophic event or emergency occur that affects multiple employees' residences, a call for applications will be requested by Human Resources, with a submission deadline. The leave bank will maintain a minimum balance of 352 hours for applications submitted for qualifying catastrophic life-threatening health conditions.

NOTE: Full-time employees may apply to the Leave Sharing Program for up to a maximum of 80 hours (10 work days) per application for a catastrophic event or emergency affecting an employee's residence. This maximum applies to both situations listed above. The maximum hours will be prorated for part-time employees.

Hours Requested
Required

Full-Time employees may request up to **80 hours** (Prorated for part-time)

Requested Leave Sharing Hours

Indicate the number of hours requested by using the worksheet below. ***If you need assistance in determining the number of hours to request, please contact your department personnel/payroll coordinator or Human Resources.*** Leave sharing hours may only be used when the employee has inadequate paid time-off accumulated to cover the absence.

Last Day Worked:_____

Date ALL Accumulated Paid Leave is Exhausted: _____

Difference Between _____ → _____ = _____ x _____ = _____

Date Paid Leave Exhausted | Date of Return | Days | Hours | Total Hours Requested

Attestation of Catastrophic Event or Emergency affecting Employee's Residence

What catastrophic event or emergency affected your residence?

☐ Flood ☐ Tornado ☐ Wildfire ☐ Other Natural Disaster _____

☐ Accidental Event _____

When did the catastrophic event or emergency occur? _____/_____/_____

Where did the catastrophic event or emergency occur?_____

Anticipated duration your absence, due to the catastrophic event or emergency affecting your residence:

From_____/_____/_____ To _____/_____/_____

Please explain in detail how this catastrophic event or emergency affected your residence (i.e. total destruction, partial destruction, etc.):_____

_____

_____

_____

_____

I hereby certify that the information contained herein is true and accurate.

Applicant Signature:_____ **Date:** _____

(electronic signature accepted)

Part III: Qualifying Leave Sharing Situations

Scenario #4

(Please complete only **ONE** of the Leave Sharing scenarios)

An Employee Serving as a First Responder

☐ **An Employee Serving as a First Responder -** A firefighter, paramedic, National Guard member, etc. called to respond to duty, due to a catastrophic event or emergency.

- *Examples: Wildfire, flood, tornado, or other natural disaster, or accidental event such as a fire or natural gas explosion, etc.*

Hours Requested

Required

Full-Time employees may request up to **40 hours**
(Prorated for part-time)

Requested Leave Sharing Hours

Indicate the number of hours requested by using the worksheet below. ***If you need assistance in determining the number of hours to request, please contact your department personnel/payroll coordinator or Human Resources.*** Leave sharing hours may only be used when the employee has inadequate paid time-off accumulated to cover the absence.

Last Day Worked:_____

Date ALL Accumulated Paid Leave is Exhausted: _____

Difference Between _____ → _____ = _____ x _____ = _____

Date Paid Leave Exhausted | Duration of Duty | Days | Hours | Total Hours Requested

Attestation of Employee Serving as a First Responder

In what capacity were you serving as a First Responder?

☐ Firefighter ☐ Paramedic ☐ Police ☐ National Guard Member ☐ Other _____

(May not be in a volunteer capacity – must be official business)

For what catastrophic event or emergency were you serving as a First Responder?

☐ Flood ☐ Tornado ☐ Wildfire ☐ Other Natural Disaster _____

☐ Accidental Event _____

What date were you called to respond? _____/_____/_____

Anticipated duration of your absence, due your call to respond to duty as a First Responder:

From_____/_____/_____ To _____/_____/_____

Explain in detail why you are requesting leave sharing hours for the catastrophic event or emergency in which you served as a first responder:

_____

_____

_____

_____

_____

_____

I hereby certify that the information contained herein is true and accurate.

Applicant Signature:_____ **Date:**_____

(electronic signature accepted)

Part III: Qualifying Leave Sharing Situations

Scenario #5

(Please complete only **ONE** of the Leave Sharing scenarios)

An Employee who is on Active Military Service and is Experiencing Serious Financial Hardship During the Initial Call to Duty

☐ **An Employee who is on Active Military Service and is Experiencing Serious Financial Hardship During the Initial Call to Duty**
The leave sharing hours are limited to making up the difference between the employee's base salary and the total gross military pay and allowances. Documentation may be required to substantiate financial hardship.

Hours Requested
Required

Full-Time employees may request up to **40 hours**
(Prorated for part-time)

Requested Leave Sharing Hours

Indicate the number of hours requested by using the worksheet below. ***If you need assistance in determining the number of hours to request, please contact your department personnel/payroll coordinator or Human Resources.*** Leave sharing hours may only be used when the employee has inadequate paid time-off accumulated to cover the absence.

Last Day Worked:_____

Date ALL Accumulated Paid Leave is Exhausted: _____

Difference Between _____ → _____ = _____ x _____ = _____

Date Paid Leave Exhausted | Date of Call to Duty | Days | Hours | Total Hours Requested

Attestation of Employee's Serious Financial Hardship During the Active Military Service Initial Call to Duty

When were you required to report to active duty, based on your military orders (please attach) _____/_____/_____

When were you notified to report to active duty? _____/_____/_____

Anticipated duration of your absence, due your call to respond to active duty:

From_____/_____/_____ To _____/_____/_____

Please explain in detail what type of financial hardship you experienced, due to your initial call to active duty:_____

_____

_____

_____

_____

_____

_____

I hereby certify that the information contained herein is true and accurate.

Applicant Signature:_____ **Date:**_____

(electronic signature accepted)

Part IV: Employee Authorization

Genetic Information Nondiscrimination Act of 2008 (GINA)

Pursuant to the Genetic Information Nondiscrimination Act (GINA)'s "safe harbor" provision in 29 CFR § 1635.8(b)(1)(i), the GINA disclosure language (see instructions for Healthcare provider) must be included with any request for employment-related medical information or examinations (e.g., FMLA for employee, ADA, Fitness-for-Duty exams, Workers' Compensation exams, post-offer/pre-employment exam, etc.) for the individual's own condition.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. However, please be advised that GINA Title II does allow you to provide information about the medical condition of an employee's spouse, parent or child to certify the need for leave under the Family Medical Leave Act (FMLA).

PHYSICIAN'S STATEMENT documenting the condition and verifying dates when the medical condition began and the expected return to work MUST be completed.

I hereby certify that I understand, agree to and meet the requirements and conditions of the leave sharing program. I also understand that a representative of CSU Human Resources may contact me or my department, or others as deemed appropriate, for information concerning this application. I understand that denial of this application is not subject to grievance or appeal. I understand this application will be returned if all sections are not complete and/or a physician medical statement is not complete.

Applicant:_____
(Print Name)

Applicant Signature: **Date:**
(electronic signature accepted)

Part V: To be completed by your Department Personnel/Payroll Coordinator

Employee's Status: ☐ Full-Time **or** ☐ Part-Time _____% #Hours Worked each Week:_____

Last Day Worked _____/_____/_____ #Hours Worked on Last Day:_____

Date **ALL** accumulated paid leave time is exhausted*: _____/_____/_____
(annual leave, sick leave, compensatory time or accrued holiday time)
*if applicable, based on scenario applied for
#Paid Leave Hours Used on this Date:_____

Note: Ensure you process Leave Without Pay (LWOP) information in Oracle.

Department Personnel/Payroll Coordinator:_____ Phone (_____)_____
(electronic signature accepted)

I hereby certify that the information contained herein is true and accurate to the best of my knowledge.

Department Personnel/Payroll Coordinator Signature:_____ **Date:**_____
(electronic signature accepted)

Part VI: To be completed by your Supervisor

How long have you been supervising the applicant? _____Years _____Months

I hereby certify that, to the best of my knowledge, the information provided in Parts I, II and III are accurate. Also, I hereby certify that leave for the purpose indicated in this application has been or will be authorized by me should this application be approved.

Supervisor:_____ Phone (_____)_____
(Print Name)

I hereby certify that the information contained herein is true and accurate to the best of my knowledge.

Supervisor Signature:_____ **Date:**_____
(electronic signature accepted)

- Vice President for University Operations Use Only -	
To be completed by Vice President for University Operations	
☐ Request Approved	☐ Request Denied
Signature:_____ Lynn Johnson, Vice President for University Operations	Date: _____

- Human Resources Use Only -			
Application Routing	**Date/Initials**	**Approval Process**	**Processing Data**
Application Received		Years of Service (Continuous SC CSU employment – minimum one year)	_____Years _____Months
Department Notification Letter Sent			
Leave Sharing Committee Review		Occupational Group	
VPUO Review		Number of Hours Approved	_____Hours
Approval or Denial letter to Applicant		Number of Hours Used	_____Hours
Leave Sharing Spreadsheet entry		Number of Direct Donation Hours	_____Hours
Payment Request Sent to Payroll *(if applicable)*			
Award Tracking (Approved Applications – 7/1/2007 and After)			
Years 2 - 5 (One Award (approved application) Allowed)		Date of Award_____/_____/_____	
Years 5+ (Three Awards (approved applications) During Career Allowed)		Date of Award_____/_____/_____ Date of Award_____/_____/_____ Date of Award_____/_____/_____	
Intermittent Request (May only be used for six months after the first date of Leave Sharing Program hours usage)		Six-Month End Date_____/_____/_____	
Comments:			