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ODOT Human Resources

Request for Hardship/Bereavement Leave

Employee's Name: _____ Crew # _____ Employee Identification Number: OR _____

☑ **New Request** ☐ **Extension Request**

In accordance with applicable labor contract and/or policy, I am requesting Hardship Leave Donations from other ODOT employees for the following reason (check the most appropriate box):

☐ I have a health condition OR ☐ I need to care for a family member with a health condition expected to continue:

- ☐ 30 days after my accrued leave has been exhausted (AEE).
- ☐ 15 days after my accrued leave has been exhausted and the total leave is at least 30 consecutive days (SEIU, Management Services, Unrepresented and Executive Services).

Number of hours requested: _____ **You must state a specific number of hours or your request will not be processed.**

By signing below I understand that my use of donated leave as sick leave may offset the receipt of any disability payments[1]. I understand that if I am out more than four consecutive weeks, I may be requested to have my health care provider re-certify my condition. I also understand that donations will be used to reimburse the Agency for costs incurred for insurance contributions which I am eligible to receive as a result of the use of Hardship Leave Donations, unless the leave is covered by FMLA. The Agency is held harmless from employee tax liability.

My health care provider's signature on the attached and completed Hardship Leave Donations form verifies the medical reason and estimated number of hours needed. I understand if additional hours are needed, another signed Health Care Provider Certificate for Hardship Leave Donations is required.

_____ _____

Employee's Signature Date

Please mail or fax this form to your Human Resources representative.

For Human Resources Use:

Is this an FMLA qualifying event: Yes ☐ No ☐ FMLA Exhaustion Date: _____

SAIF Claim: ☐ Filed ☐ Denied ☐ Appealed

As of (date) _____, current leave balances were: Vacation: _____ Sick Leave: _____ Comp: _____ Personal: _____

Request is: ☐ Approved ☐ Denied (reason provided below):

_____

_____

Dates of Leave Approval: From: _____ To: _____ HR Representative Signature & Date: _____

[1] Refer to your disability insurance policy materials for more information.

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