

State Leave Sharing Program/Recipient Form

Section A: To be completed by Employee Recipient

Employee Name (PRINT)

State Employee ID#

Job Title

Facility/Unit

This is a request for approval to receive donated leave in accordance with the State Leave Sharing Program as specified in 74 O.S. § 840-2.23 and certify that it is for one of the following reasons:

- Check (✓) the reason that is applicable
1. _____ I am required to care for a relative (spouse, child, stepchild, grandchild, grandparent, stepparent, parent), or household member with a serious health condition. (Medical certification is/has been submitted and substantiates a "serious health condition" under FMLA)
 2. _____ I am unable to perform the functions of my job due to my own serious health condition. (Medical certification is/has been submitted and substantiates a "serious health condition" under FMLA)
 3. _____ I have been approved for family and medical leave for the birth or care of my newborn child
 4. _____ I have been approved for family and medical leave for the placement of a child for foster care or adoption. (Required documentation was previously submitted and is qualifying for family and medical leave)
 5. _____ As a result of a presidentially declared national disaster:
(✓ any applicable circumstance)
_____ I suffered a physical injury
_____ I have a relative or household member who suffered a physical injury or died
_____ My home or the home of a relative has been damaged or destroyed.
 6. _____ The recent death of a relative or household member. Date of death: _____
 7. _____ I have been approved for military family leave (MFMLA) due to a qualifying exigency arising out of my spouse, child, or parent who is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.
 8. _____ I have been approved for military family leave (MFMLA) to care for a covered military service member (spouse, child, parent, next of kin) who is recovering from a serious illness/injury sustained in the line of duty on active duty.

List any periods of employment with other state agencies during which you used leave that was donated and the number of days you were absent from work on donated leave:

_____/_____
Past Employer # of days

_____/_____
Past Employer # of days

Signature of Employee

Date

Section B: To be completed by the Human Resources Management Specialist

Please check (✓) all items that are verified as correct:

- The Employee Recipient: _____ Is a permanent classified or regular unclassified employee; or a probationary employee who is applying for shared leave due to the effects of a presidentially declared national disaster
- _____ Has a minimum of one year of continuous service with the state

- _____ Has exhausted or is about to exhaust all accrued sick and annual leave balances which is likely to cause the employee to go on leave without pay or terminate employment and all other paid leave available
- _____ Has not exhausted the 261 day (2088 hours) limit for shared leave during total state employment (or 365 day limit for terminal illness, or other limit as established by the department)
- _____ Has no pending disciplinary action or formal department investigation or investigation by an external agency (i.e. workers compensation claim is under investigation or criminal investigation)
- _____ Has submitted a Medical Certification Form.

Is this request due to a presidentially declared disaster? _____ Yes (or) _____ No
If yes: _____ The period of absence, for which donated leave is requested, falls within 18 months of the declaration

Current leave balances: Sick: _____ Annual: _____ Holiday: _____ Admin(AE): _____ Comp Time: _____

Date Request Expires: _____ /Reason: Check (/) one:
_____ Ending Date of Medical Certification
_____ End Date of 12 weeks FMLA for birth of child and to care for child; or placement for adoption or foster care of a child
_____ End date of the five (5) day calendar year limit for the death of a relative or household member
_____ The 261 day, 365 day or other limit expires prior to any other expiration date
_____ Other _____

Signature of HRMS Date

Section C: To be completed by the Facility/Unit Head

I have reviewed the information on this form and the Medical Certification Form.

This request to receive donated leave is:

- _____ Approved Per the completed Medical Certification Form the employee will:
Be off work continuously beginning: _____ ending: _____
Work a reduced schedule beginning: _____ ending: _____
Be absent intermittently during the period beginning: _____ ending: _____
- _____ Denied The Employee Recipient does not meet all eligibility requirements or the medical certification/documentation is insufficient

The request to receive/use shared leave was reviewed for designation of FMLA/MFMLA; the following determination made:

- Leave has been designated as FMLA until _____ and will be counted towards the 12 week entitlement*
- Leave has been designated as MFMLA until _____ and will be counted towards the 12 week entitlement
- Leave has been designated as MFMLA until _____ and will be counted towards the 26 week entitlement
- Leave has not been designated as FMLA/MFMLA

* Please note that absences for the serious illness of a grandparent or grandchild do not qualify for FMLA

My signature certifies that I have reviewed the above information and it is correct to the best of my knowledge. It also certifies that if the leave has been designated as FMLA &/or MFMLA then I have provided the requesting employee with the "Employer's Notice to Employee" (FMLA)/(MFMLA) – Page 2 of Attachment G for OP-110355.

Signature of Facility/Unit Head Date

Employer's Notice to Employee (FMLA)

1. All leave designated as family and medical leave (FMLA) will be counted towards your annual 12 week entitlement.
2. Family and medical leave may be paid or unpaid and you may elect to use accrued sick or annual leave, or compensatory time (exempt employees only) in lieu of unpaid leave. Your failure to specify that a leave request is for family and medical leave does not prevent the department from designating leave as family and medical leave when appropriate.
3. If medical certification is required or has been requested:

Failure to provide complete medical certification may result in denial or delay of requested leave. Additional medical certification will be required not more often than every 30 days or when you request an extension of intermittent leave or leave that was originally approved for more than 30 days. The department may also require recertification if the circumstances described in your current certification change significantly or we receive information that casts doubt on your stated reason for absence.
4. You may be required to provide the department with certification that you are fit for duty prior to returning to work for any absence that was taken for your own serious illness. This requirement will not apply when leave is taken on an intermittent basis.

Employer's Notice to Employee (MFMLA)

1. All leave designated as military family leave (MFMLA) for a qualifying exigency will be counted towards your annual 12 week entitlement. This entitlement in combination with any use of family and medical leave (FMLA) cannot exceed 12 work weeks (480 hours) total during a 12 month period.
2. All leave designated as military family leave (MFMLA) to care for a covered military service member will be counted towards your annual 26 week entitlement. This entitlement in combination with any use of family and medical leave (FMLA) and/or any use of military family leave (MFLMA) for a qualifying exigency cannot exceed 26 work weeks (1040 hours) total during a single 12 month period. However, this will not limit the availability of leave under standard FMLA or MFMLA for a qualifying exigency during any other 12 month period.
3. Military family leave may be paid or unpaid and you may elect to use accrued sick or annual leave, or compensatory time (exempt employees only) in lieu of unpaid leave.
4. If the military service member medical certification is required or has been requested, failure to provide a completed military service member medical certification may result in denial or delay of requested leave.
5. The department may require you to provide confirmation that an instance of intermittent leave is related to the military family leave event for which the MFMLA intermittent leave was originally granted.

Distribution: Original to Personnel File, Copy to Employee, Copy (attached to Donor Form) to Central Human Resources Unit (R 10/18)