



ODOT Human Resources

Request for Hardship or Bereavement Leave Donations

Employee's Name: _____ Crew # _____ Employee ID Number: **OR** - _____

New Request **Extension Request** **Hardship Leave** **Bereavement Leave**

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

- I have a health condition OR I need to care for a family member with a health condition expected to continue 15 days after my accrued leave has been exhausted and the total leave is at least 30 consecutive days.
(AEE/SEIU/and Management/Executive Services and Classified Unrepresented)
- I have had a death of an immediate family member and am requesting Bereavement Leave donations.

Please verify the following and check the appropriate box or boxes:

- I **am** or **am not** eligible for or receiving Worker's Compensation benefits.
 I **am** or **am not** applying for or receiving Short Term or Long Term Disability benefits.

I am requesting _____ hours. You ***must*** state a specific number of hours or your request will not be processed.

By signing below, 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

Dates of Leave Approval: From: _____ To: _____ Approving Manager: _____

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

For Human Resources Use:

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

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

Request is: Approved Denied (reason provided below):

If a donation request involves another state agency, an ODOT Appointing Authority or their designee's signature is required:

Appointing Authority or Designee Signature

Date

HR Representative Signature & Date: