**APPENDIX A**

**WEST VIRGINIA DEPARTMENT OF EDUCATION LEAVE DONATION PROGRAM**

**APPLICATION TO RECEIVE DONATED LEAVE**

**PART I - Applicant Information: To be completed by the applicant or designee.**

**PLEASE PRINT OR TYPE**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Name: | | | 1. Social Security Number: |
| 1. West Virginia Department of Education | 1. Section | | 1. Unit: |
| 1. Work Phone: | | 1. Home Phone: | |
| 1. Reason for Request:  Personal Medical Condition  Medical Condition of Immediate Family Member   8a. Work-related?  Yes  No 8b. Relationship: | | | |
| **The reason for the request must be verified by the physician or medical practitioner treating the individual with the medical condition. The physician or medical practitioner must provide all the information requested on the back of the form (PART III) and he/she must sign and date the form.** | | | |
| 1. In applying for leave donations, I agree to have the following information published: my name, the agency I work for, the reason for my request, my last day at work, the date my leave available for this absence was or will be exhausted, and the expected duration of my absence. | | | |
| 9a. Signature: | | 9c. Completed by:  Applicant | |
| 9b. Date: | | Designee (specify): | |
| 1. **OPTIONAL: TO BE COMPLETED ONLY BY THE APPLICANT.** As part of my application for leave donations, I further request that you also publish the following information regarding my medical emergency exactly as I have written it in the space below. | | | |
| 10a. Signature: | | 10b. Date: | |

**PART II – To be completed by the applicant’s Appointing Authority or Designee.**

|  |  |
| --- | --- |
| 1. Does the applicant receive annual and sick leave as a benefit or employee?  Yes  No 2. For this absence, is the applicant receiving/eligible to receive Workers’ Compensation benefits, or is he/she receiving Social Security Disability benefits?  Yes  No 3. The applicant’s leave available for this absence was/will be exhausted on (date): 4. The applicant, according to the information provided in **PART III**, is expected to be absent from work until (date): 5. The leave of absence is:  Medical (Self)  Personal (Immediate Family) 6. The applicant is:  **ELIGIBLE** to receive the leave donation.   **NOT ELIGIBLE** to receive the leave donation.  QUESTIONS?  Please call the person name in  item 8.  6a. **REASON:**   1. FIMS account information for recipient: | |
| 1. Certified by: | 1. Date: | |
| 1. Title: | 1. Phone: | |

**WEST VIRGINIA DEPARTMENT OF EDUCATION LEAVE DONATION PROGRAM**

**PART III – To be completed by patient’s physician or medical practitioner.**

The employee named in Part I has applied to receive donations of annual leave through the Leave Donation Program established by the West Virginia Department of Education. You are requested to complete the information below for your patient, either the named employee or a member of the named employee’s immediate family. If your patient is the named employee, please complete items, 1, 2, 3, 4a, 5a, 6, 7, 8 and 9. If your patient is a member of the named employee’s immediate family, please complete items 1, 2, 3, 4b, 5b and 9.

**PLEASE PRINT OR TYPE**

|  |  |
| --- | --- |
| 1. Patient’s name: | 1. Most recent date of examination: |
| 1. The patient is/was:  Under My Professional Care FROM       TO         Hospitalized FROM       TO | |
| 1. The patient is:   **4a. EMPLOYEE**  **4b. FAMILY MEMBER OF EMPLOYEE**   The patient has been incapacitated from performing The absence of the named employee from work  His/her job duties Has been necessitated by the medical condition  of the patient  FROM       TO       FROM       TO   1. Return to duty information:   **5a.** The patient has resumed or may resume **full duty 5b.** The patient will no longer need the care/attendance  **Employment**, with no restrictions on work of the named employee which would require the  Activities beginning (date): absence of the named employee from work  Beginning (date): | |
| **[NOTE: Please give a date, even if it is approximate. As an alternative, you may give the date you will next evaluate the patient’s condition.]** | |
| 1. If the patient is not able to return to full duty employment, can the patient return to work at less than full duty?   No  Yes If yes, period of partial incapacity: FROM       TO | |
| 1. Describe in detail any limitations or restrictions on the ability of the employee to work. Please list any assistive devices or equipment or any other type of accommodation the employee requires to perform his/her job duties. | |
| 1. Will this illness or injury **permanently** prevent the employee from returning to work?   Yes  No | |
| 1. **PHYSICIAN’S OR**   **PRACTITIONER’S NAME:** | |
| **ADDRESS:** | **PHONE:**  (304) |
| **SIGNATURE:** | **DATE:** |