STATE OF IDAHO DONATED LEAVE REQUEST FORM

All Donated Leave Requests will be kept anonymous.

I, the undersigned, certify that I meet <u>all</u> the following criteria;

☐ I am eligible to accrue sick and vacation leave;

☐ Prior to receiving any donated leave time, I will have exhausted ALL my accrued leave such as compensatory, sick and vacation leave;

☐ I have not exceeded the maximum of one-hundred sixty (160) hours of donated leave this fiscal year.

Employee Name: ________________________________ **Job Title:** ___________________________

Employee ID: ____________ **Agency Code:** ______________ **Date of Hire:** ___________________

Total Amount of Leave Available (hrs.): ____ **Vacation:** ____ **Sick:** ____ **Comp:** ____ **Other:** ____

Number of Hours Requested: ____________________ *If amount of time needed is known, only request that amount of needed time. Below justification must support amount of time requested.*

Justification/Reason for Leave *All requests must be substantiated by medical documentation supporting the request is for the employees' own serious illness or disability or for a qualifying family member with a serious illness or disability.*

Medical Documentation Provided to HR: ☐ Yes ☐ No

Employee Signature: _______________________________________ **Date Signed:** ______________

Below Section is for Human Resources

Number of Hours Approved: ________________ **Effective Pay Date:** _________________________

HR Representative Signature: ________________________________ **Date Signed:** ______________

Donated Leave Requests must be submitted through the Luma Service Portal