



STATE OF IDAHO DONATED LEAVE REQUEST FORM

All Donated Leave Requests will be kept anonymous.

I, the undersigned, certify that I meet all 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: *Leave must be for the death or funeral in the family necessitating the employee's absence from work. All requests for medical reasons 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 and Appointing Authority

Number of Hours Approved: _____ **Effective Pay Date:** _____

HR Representative Signature: _____ **Date Signed:** _____

Appointing Authority Signature: _____ **Date Signed:** _____

Donated Leave Requests must be submitted through the [Luma Service Portal](#)