West Virginia Division of Personnel

LEAVE DONATION PROGRAM
APPENDIX A

APPLICATION TO RECEIVE DONATED LEAVE

PLEASE PRINT OR TYPE

PART I – APPLICANT INFORMATION: To be completed by the applicant or designee.

Name:	Social Security Number:	
Agency:	Work Phone:	Home Phone:
Section (and Unit if applicable):		

Reason for Request:
☐ Employee's Personal Medical Condition
☐ Immediate Family Member's Medical Condition
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 of the information requested on the back of this form (PART III), and he/she must sign and date the form.

In applying for leave donations, I agree to have the following information published:

- My Name
- The agency for which I work
- My last day at work
- The date my available leave was/will be exhausted
- The reason for my absence
- The expected duration of my absence

Signature Date:

Completed by: ☐ Applicant ☐ Designee (specify):

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:

Signature Date:

PART II – EMPLOYER DETERMINATION: To be completed by the applicant's Appointing Authority or designee.

1. Does the applicant receive annual and sick leave as a benefit of employment?	☐ YES	☐ NO
2. For this absence: Is the applicant receiving/eligible to receive Worker's Compensation benefits, or is he/she receiving Social Security Disability benefits?	☐ YES	☐ NO
3. The applicant's available leave for this absence was/will be exhausted on:	Date:	
4. The applicant, according to the information provided in PART III of this form, is expected to be absent from work through:	Date:	
5. This leave of absence is for the following reason:	☐ Medical Condition: Employee ☐ Medical Condition: Immediate Family Member	
6. The applicant's eligibility determination is:	☐ ELIGIBLE	☐ NOT ELIGIBLE: explain below
7. OASIS account information for recipient:		
8. Certified by:	10. Phone:	
9. Title:	11. Date:	

PART III – PHYSICIAN/PRACTITIONER INFORMATION: To be completed by the 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 Division of Personnel. You are requested to either complete the information below or attach a completed DOP-L3 Physician's/Practitioner's Statement form for your patient.

If your patient is the named employee, complete items 1, 2, 3, 4a, 5a, and 6 through 13. If your patient is a member of the named employee's immediate family, complete items 1, 2, 3, 4b, 5b, and 9 through 13.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PLEASE PRINT OR TYPE

<table>
<tr><td colspan="2">1. Patient's Name:</td><td colspan="2">2. Most recent examination date:</td></tr>
<tr><td colspan="2">3. Patient is/was:
☐ Under my professional care
☐ Hospitalized</td><td>FROM
FROM</td><td>TO
TO</td></tr>
<tr><td colspan="4">4 and 5. COMPLETE THE APPROPRIATE SECTIONS (4a and 5a –OR– 4b and 5b) BELOW: Provide a return to duty date for either section, even if it is approximate. As an alternative, you may give the date you will next evaluate the patient's condition.</td></tr>
<tr><td colspan="2">4a. Patient is:
☐ The employee, and has been incapacitated from performing and is/her job duties
FROM TO
5a. Return to duty information: The patient/employee has resumed or may resume full duty employment, with no restrictions on work activities, on:
DATE:</td><td colspan="2">4b. Patient is:
☐ A family member of the named employee, and the employee's absence from work has been necessitated by the medical condition of the patient
FROM TO
5b. Return to duty information: The patient will no longer need the care/attendance of the named employee, which would require the absence of the employee, on:
DATE:</td></tr>
<tr><td colspan="2">6. If the patient is not able to return to full duty employment, can he/she return to work at less than full duty?
If yes, what is the period of incapacity?</td><td>☐ YES
FROM</td><td>☐ NO
TO</td></tr>
<tr><td colspan="4">7. 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 in order to perform his or her job duties.</td></tr>
<tr><td colspan="2">8. Will this illness/injury permanently prevent the employee from returning to work?</td><td>☐ YES</td><td>☐ NO</td></tr>
<tr><td colspan="4">9. Physician's or Medical Practitioner's Name:</td></tr>
<tr><td colspan="3">10. Address:</td><td>12. Phone:
13. Fax:</td></tr>
<tr><td colspan="3">11. Signature</td><td>14. Date:</td></tr>
</table>