Arizona State Personnel System

Request to Receive Donations of Annual Leave (DAL)

Employee Name		EIN		Date	
Agency		Division		Unit	
Supervisor's Name		Supervisor's E-mail			
Employee's Personal Phone Number		Employee's Work Phone Number			
Personal E-mail		Work E-mail			
Home Street Address		City		Zip Code	

☐ The leave is due to my own medical condition

☐ The leave is due to my family member's medical condition

If the leave is due to an immediate family member's medical condition, indicate which family member you are taking leave to care for

☐ Parent ☐ Spouse ☐ Child

Family Member's Name

Anticipated Leave Start Date		Anticipated Leave End Date	
Healthcare Provider's Name		Healthcare Provider's Telephone Number	
Healthcare Provider's Address			

Read and initial your understanding of each statement below:

☐ In order to qualify to receive donations of annual leave my absence must be for my own or a family member's seriously incapacitating and extended illness or injury or a seriously incapacitating and extended disability caused by pregnancy or child birth.

☐ The duration of my leave must be for at least three consecutive weeks.

☐ It is my responsibility to provide to my Human Resources Representative a copy of my Healthcare Provider's certification of prognosis and my anticipated date of return to work. All information I provide will be kept confidential and shared only with those with a need to know.

☐ I must exhaust all of my applicable sick, annual, holiday and compensatory leave prior to the use of any annual leave donations.

☐ If this request is to take leave to care for a family member, I must have used 40 hours of family sick leave, if available, during this calendar year, and exhausted all annual and other paid leave balances.

☐ If I am unable to return to work on the approved end date of my leave, it is my responsibility to provide an updated prognosis and an anticipated date of return certification from my Healthcare provider. The certification must be provided prior to the approved end date of my leave.

☐ Donations of annual leave will not be retroactively applied. Rather, donations may be used once the eligibility requirements are met and the Human Resources Representative receives both my completed request form and my medical certification.

☐ I may be eligible for donations for up to six months from the start of my leave. This period may only be extended to allow a determination to be made for Long Term Disability (LTD) benefits if I applied for LTD benefits by the end of the fifth month of my leave.

☐ If I am awarded LTD benefits, I will no longer be eligible to receive donations and any unused donations I have received will be returned to the applicable contributors.

☐ Upon my return to my regular schedule, all unused donations will be returned to the applicable contributors.

My signature indicates I understand and will comply with the requirements of the donated annual leave program.

Printed Name		Signature		Date	

Donation of annual leave is defined in ASPS Rule R2-5A-B602.

If the employee is unable to sign this form due to incapacity, the form may be signed on the employee's behalf. A copy of the completed form will be mailed directly to the employee by the Agency Human Resources Representative.