

Compassionate Leave Program Application for Use

Please complete the form as instructed and mail to the above address or fax to 732-932-0046. You will be notified by your immediate supervisor that the donation has been accepted. University Human Resources will make the necessary changes to your Absence Record Card.

Part 1 – To Be Completed By Employee (please type or print):

Name:	
Last	First
Middle Initial	
Date of Hire:	
Department Name:	
Campus Address:	
Request is for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse /Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Parent/Parent-in-law <input type="checkbox"/> Other (explain):	
Have you applied for (check all that apply):	
<input type="checkbox"/> Temporary Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Disability Retirement <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Family Leave	
Date illness began:	Anticipated duration of illness (# of days/weeks):
Date all sick and vacation days will be/were exhausted:	Number of days requesting:
Briefly describe the nature of the illness:	
<i>I hereby certify that I understand, agree to, and meet the requirements and conditions of the Compassionate Leave Program. Also, I hereby authorize the Vice President for Faculty and Staff Resources or designee to obtain any necessary information concerning this application. I understand that denial of this application is not subject to grievance or appeal.</i>	
Employee's Signature:	Date:

Part 2 -To Be Completed By Employee's Supervisor.

<i>I hereby certify that to the best of my knowledge the above information is accurate. I support the employee's request for donated leave.</i>	
Supervisor Name:	Supervisor Title:
Supervisor's Signature:	Date:

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Part 3 – Attending Physician’s Statement:

Please attach medical verification from your attending physician or attending physician of your family member to support this request. Donated leave cannot be granted without medical verification.

Medical verification should include nature and anticipated duration of the disability resulting from the serious health condition.

Part 4 -To Be Completed By University Human Resources:

The above named employee has exhausted all sick, vacation, AL and PH days on:

Determination:

A determination was made to transfer _____days from the Leave Bank. These days should be transferred to the employee’s Absence Reporting System and recorded as “CL” for Donated Days from Bank. The Leave Bank’s balance will be adjusted accordingly.

A determination was made to deny the employee’s request for the following reason:

UHR Employee Name:

UHR Employee Title:

Authorized Signature:

Date:

Additional comments: