



Leave Sharing Recipient Application

Employee Name: _____
Last First M.I.

Employee ID: _____

Personal Email: _____ UVA Email: _____

Home Phone: _____ Work Phone: _____

My identity ___ shall be revealed ___ shall not be revealed to potential donors.

EMPLOYEE'S CERTIFICATION:

I have provided the required medical certification to the FMLA vendor.

1. Employees must be on approved Family Medical Leave (FMLA) to receive leave sharing donations.
2. To be eligible for leave sharing donations for an employee's own illness, an employee cannot be eligible for a Short-Term Disability plan.

I shall not be required to reimburse donations unless one of the following situations occurs:

1. Compensation is received from another source for the same period of time I received leave sharing donations, such as when monies are received from the leave sharing program and subsequently workers' compensation benefits are received retroactively for that same period of time; or
2. University Human Resources determines that abuse has occurred. I shall be required to repay all donated hours, and/or may be subject to disciplinary action in accordance with the Standards of Conduct Policy.

Employee's Signature Date

SUPERVISOR'S APPROVAL:

I am aware that this employee is applying for participation in the leave sharing program.

Supervisor's Signature Date

For completion by UVA HR Solution Center, leave team:

Received hours _____ Donor _____

Authorized by _____ Date _____

Please return the completed form to the UVA HR Solution Center, leave team, via fax 434-924-4042
or email leave@virginia.edu.