Donated Leave Policy

The purpose of this section is to provide the employees of the City of Vicksburg (COV) with a donated leave program.

Employees of the COV may donate personal or sick leave to a covered employee who has exhausted all leave due to a catastrophic illness or catastrophic injury to the employee; the employee's spouse; the employee's biological child(ren), COV for at least twelve (12) months prior to the request year and must meet all other qualifications as a full time employee.

"Catastrophic injury or illness" means a life-threatening injury or life-threating illness of an employee, the employee's spouse, the employee's biological or adopted child(ren), or the employee's *parent, which totally incapacitates the employee or the employee's family member from work, as verified by a licensed physician, and forces the employee to exhaust all leave time earned by that employee. Conditions that are short-term (21 days or less) in nature, including, but not limited to, common illnesses such as influenza and the measles, and injuries that are not life threatening, are not catastrophic. Chronic illnesses or injuries, such as but not limited to cancer which result in intermittent absences from work and which are long-term in nature and require long recuperation periods may be considered catastrophic within its complete definition as listed above.

All applications to donate leave and any requests to receive donated leave must be approved by the Human Resources Director, prior to the actual transfer of the donated leave.

- Any donee may receive up twenty (20) days of donated leave during the previous twelve (12) month period.
- A donor shall maintain fifty percent (50%) of his/her individual sick leave.
- A donor shall maintain ten (10) days of his/her individual personal leave.
- All leave not used by the donee, shall be returned to the donor, on a pro rata basis. * *If the donor is no longer employed with the COV, the remaining leave shall not be used by the donee.*
- Leave may not be donated by an employee, separating/terminating/resigning his/her employment with the COV.
- Leave shall be donated in twenty-four (24) hour increments (i.e. 3 days per donation).
- If any employee is found to have or attempts to abuse this policy, he/she shall not have the benefit of requesting donated leave thereafter.

**A step-parent shall be considered a parent for this policy, only if he/she stood in loco parentis, and lived within the same household during the majority of the employee's childhood years.*

This policy supercedes the donated leave policy approved on December 22, 2016.

Effective the _____ day of _____ 2018

Mayor George Flaggs	Alderman Michael A. Mayfield	Alderman Alex J. Monsour

City of Vicksburg

Licensed Physician Verification for Donated Leave

Employee Name: _____ Date: _____

The following section must be completed by the employee's medical doctor/treating physician:

I, _____, have determined that the above referenced patient's condition *is/is not* catastrophic injury/illness within the City of Vicksburg's definition: a life-threatening injury or life-threating illness of an employee, the employee's spouse, or the employee's child(ren). I understand this definition is not based upon a life-threatening event.

How *is/is not* the above employee's condition(s) considered a catastrophic injury/Illness?

_____

_____

_____

How long will this/these limitation(s) apply?

_____

_____

_____

Are there any job-related restrictions to the performance of the patient's job when he/she returns work? If so, list those restrictions below. (Please see and initial the employee's attached job description).

_____

_____

_____

Will the patient need to continue any form of treatment once he/ she returns to work? If so, what is the frequency and duration of the treatment?

_____

_____

_____

Medical Doctor/Treating Physician:

Print Name _____

Signature _____, Date _____

CITY OF VICKSBURG

APPLICATION TO RECEIVE DONATED LEAVE

Instructions: Complete this form to apply for donated leave. Before an employee may receive donated leave, he/she must have his/her physician complete a donated leave verification form.

PLEASE PRINT OR TYPE

PART I - Employee Information: To be completed by the recipient employee.

1. Employee Name:	2. COV Employee No.:
3. Department:	4. Home/Cell Phone Number:

5. Reason for Request:

_ Personal _ Medical Condition _ Medical Condition of Immediate Family Member (spouse, parent, sibling, or child)

Work-related? _ Yes _ No

Name and Relationship: _____

Certified proof of relationship is required.

Date All Personal and Sick Leave Exhausted:

Certification:

I certify that:

1. I have been affected by a catastrophic injury or illness as described in the COV donated leave policy and verification by my treating physician. ___ Initial
2. I have or will have exhausted all personal and sick leave. ___ Initial
3. I have been employed for a total of, at least, twelve (12) months on the date on which the leave is donated. I have worked, at least, one thousand two hundred fifty (1,250) regular hours during the previous twelve month period from the date on which the leave is donated. ___ Initial
4. I have a condition that is not short-term in nature (21 days or less). ___ Initial

In applying for leave donations, I authorize Human Resources Department to release my name to employees wishing to donate leave.

_ Yes _ No

9. Employee's Signature:	10. Date:
11. Witness Signature:	12. Date:

PART II - To be completed by Human Resources Department

1. Employment Date:	2. No. of hours worked in past 12 months:
3. First Day Donated Leave Used:	4a Beginning Date of Look Back **(12 months prior to No. 3):**
	4b. No. of Hours Worked:
5. Has the applicant received 20 days of donated leave during the previous 12 month period from the date of the request? **Applicant can only receive up to 20 days in a 12 month period.*	6. Has applicant been employed for 12 months and worked 1250 hours during previous twelve month period from the date on which leave would be donated?
7. The applicant is: _ **ELIGIBLE** to receive the leave donation. _ **NOT ELIGIBLE** to receive the leave donation. Reason:	
Approved by:	Date:
Title:	Phone Number:

CITY OF VICKSBURG

APPLICATION TO DONATE LEAVE

Instructions: Complete this form to donate accrued personal or sick leave to a designated COV recipient employee. **Donated leave shall be in increments of 24 (twenty-four) hours.** A Donee may receive a maximum of twenty (20) days of leave during the previous 12 month period. A Donor shall maintain 10 days of his/her individual personal leave and 50% of individual sick leave. Leave shall not be donated by an employee separating/terminating/resigning his/her employment. Leave not used by a Donee shall be returned on a pro rata basis. *A DONOR SHALL NOT RETAIN UNUSED DONATED LEAVE UNDER ANY CIRCUMSTANCE.*

PLEASE PRINT OR TYPE

PART I - Applicant Information: To be completed by the applicant.

1. Applicant's Name:	2. Applicant's COV ID No:
3. **Personal leave** to donate: _____ Balance after donation: _____	4. **Sick leave** to donate: _____ Balance after donation: _____
5. Designated Recipient's Name:	6. Recipient's E-mail Address:
7. Recipient's Department:	8. Recipient's Departmental Phone Number:

Certification Of Voluntary Donation

In accordance with Mississippi Code of 1972, Sections 25-3-93, 25-3-95, and 25-3-91, I am applying to make a voluntary donation of personal and/or sick leave as indicated above. I certify that I am making this donation entirely of my own free will and that no attempts have been made to coerce, threaten or intimidate me to donate my personal or major medical leave. I am donating these hours to be used by a recipient employee suffering from a catastrophic injury or illness or who has an immediate family member suffering from a catastrophic injury or illness which totally incapacitates the employee from work, as verified by a licensed physician, and forces the recipient employee to exhaust all leave time earned by that employee, resulting in the loss of compensation from the state for the employee. I understand that if the total amount of leave I have donated is not used by the recipient employee, the donated leave will be returned to me on a pro-rata basis, based on the ratio of the number of days of leave donated by each donor employee to the total number of days of leave donated by all donor employees. I further understand that I am relinquishing my rights to any future benefits of the donated leave.

9. Applicant's signature:	10. Date:

PART II - Department Authorization: To be completed by the applicant's department.

1. Department:	2. Departmental Phone Number:
3. Has applicant tendered notice of separation/termination/resignation from employment? ___ Yes ___ No	
4. Applicant's Department Head Signature:	5. Date:

PART III - To be completed by Human Resources Management.

1. Applicant's balance of leave remaining after deducting the leave donation:	Personal: Sick:
2. ____ **ELIGIBLE** to make donation.	____ **NOT ELIGIBLE** to make the donation
3. Approved by:	4. Date:
5. Title:	6. Phone Number: