HAZLEHURST CITY SCHOOL DISTRICT
119 Robert McDaniel Drive
Hazlehurst, M$ 39083

Mr. Cloyd Garth Jr., Superintendent
Phone: (601)894-1152 *Fox: (601) 894-3170*

DONATION OF MAJOR MEDICAL LEAVE

As per school board policy GBRI)
PART 1 OF 3

"Catastrophic injury or illness" means a life-threatening injury or illness of an employee or a member of an employee's immediate family that totally incapacitates the employee from work, as verified by a licensed physician, and forces the employee to exhaust all leave form *earned by that employee, resulting in the loss Of compensation from that employee. Conditions that are short-term in nature, including, but not limited to, common illnesses such as influenza and the measles, and common injuries, are not catastrophic. Chronic illnesses or injuries such as cancer or major surgery, that result in intermittent absences from work and that are long-term in nature and require long recuperation periods may be considered catastrophic.*

"Immediate family" means spouse, parent, stepparent, sibling, child or stepchild.

To Be Completed by Recipient Employee:

Name____School ____________________________________

Beginning date of catastrophic injury or illness:____

Anticipated date of return to work:____

Comments: ____

____

____

Please note: Part 2 — (Physician's Certification Form) ***must be attached to this form***. Leave may be donated only in the event that the employee has exhausted all applicable leave. The maximum amount of total donated leave days an employee may receive is 60.

____ ____
Employee's Signature Date

APPROVAL BY:

____ ____
Leave Committee Date

____ ____
Superintendent Date

Date of Board Approval ________________________

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DONATION OF LEAVE

PHYISICIAN'S CERTIFICATION FORM

PART 2 OF 3

PART A: To Be Completed bv the Employee Requesting Donation of Leave

______________________________ ______________ ______________

Employee's Printed Name **SSN** Phone #

____

Location/Dept.

PART B: To Be Completed **bv the Patient's Physician**

Instructions: The employee named in Part A has exhausted all leave and has applied to receive donations of leave. Please complete the information below for your patient.

Definition: "Catastrophic injury or illness "is defined as a life-threatening injury or illness of an employee or a member of an employee's immediate family (spouse, parent, step-parent, sibling, child or stepchild) which totally incapacitates the employee from work, as verified by a licensed physician, and forces the employee to exhaust all leave time earned by that employee, resulting in the loss of compensation of the employee. Conditions that are short-term in nature, including, but not limited to, common illnesses such as influenza and the measles, and common injuries, are not catastrophic. Chronic illnesses or injuries, such as cancer or major surgery, which result in intermittent absences from work and which are long-term in nature and require long recuperation periods, may be considered catastrophic.	
1. In your opinion does the employee meet the "catastrophic injury or illness" definition above? YES NO (please circle one)	
2. If the patient is an immediate family member of the employee, is the employee needed to care for the family member: YES NO	
3. Date injury/illness began:	
4. Describe the injury or illness and give Prognosis for Recovery:	
5. Date the employee will be able to return to work:	
Physician's Name and Address (Print):	
Physician's Signature:	Date:

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DONATION OF MAJOR MEDICAL LEAVE

PART 3 of 3

To Be Completed By Donor Employee:
(An employee may not donate more than 50% of unused accumulated leave; employee must retain at least 7 days of personal leave.)

Employee that leave is to be donated to: ____________________________

School or Department: ____

Number of days to be donated: ____________________________________

____
Printed Name of Donating Employee

____
Signature of Donating Employee

____
Date

To Be Completed By HR PERSONNEL:

Donation of Leave Approved: Yes ________ No ________

____________________________________ ________________________
Signature of HR Department Personnel **Date**