MISSISSIPPI UNIVERSITY FOR WOMEN
APPLICATION TO RECEIVE DONATED LEAVE

Instructions: Complete this form to apply for donated leave. Before an employee may receive donated leave, you must have the physician complete the second page of this form, which provides MUW with the beginning date of the catastrophic injury or illness, a description of the injury or illness, and a prognosis for recovery and the anticipated date that you will be able to return to work.

PLEASE PRINT OR TYPE

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

1. Employee Name: _____
2. MUW ID No.: _____
3. Department: _____
4. Home Phone Number: _____
5. Reason for Request: ☐ Personal Medical Condition Work-related? ☐ Yes ☐ No
   ☐ Medical Condition of Immediate Family Member
   (spouse, parent, step-parent, sibling, child, or step-child)
   Name and Relationship: _____

The reason for the request must be verified by the physician treating the individual with the medical condition. The physician must provide all of the information requested on page 2 of this form (PART III), sign and date the form.

Date All Compensatory, Personal and Major Medical Leave Exhausted: _____

Certification:

I certify that:

1. I have been affected by a catastrophic injury or illness as described in Part III (Physician's Certification).
2. I have or will have exhausted all compensatory, personal and major medical leave.
3. I have been employed for a total of at least twelve (12) months on the date on which the leave is donated.
4. I have been employed for at least one thousand two hundred fifty (1,250) hours of service during the previous twelve month period from the date on which the leave is donated.

In applying for leave donations, I authorize Human Resources to release my name to employees wishing to donate leave. ☐ Yes ☐ No

Medical Release: I authorize the release of any information necessary to process this request.

Employee's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PART II - To be completed by Human Resources

1. Employment Date: _____ 2. No. of hours worked in past 12 months: _____
3. Has the applicant been employed for 12 months on the date on which leave would be donated?
   ☐ Yes ☐ No
4. Has applicant worked 1250 hrs. during previous twelve month period from the date on which leave would be donated? ☐ Yes ☐ No

The applicant:

☐ **meets** employment requirements as stated in MS Code § 25-3-95

☐ **does not meet** employment requirements as stated in MS Code § 25-3-95

Reason**:** _____

HR Representative: _____ Date: _____

Title: _____ Phone Number : _____

PART III - To be completed by Patient's Physician.

Instructions: The employee named in Part I has exhausted all leave and has applied to receive donations of leave as established by Sections 25-3-93, 25-3-95 and 25-3-91 of Mississippi Code of 1972. 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 step-child) 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 from the state for 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/family member meet the "Catastrophic Injury or Illness" definition above? ☐ Yes ☐ No (Check one)

If no, sign and date this form. Please return completed form to address below.
If yes, answer questions 2-5.

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: _____

Mississippi University for Women requests this information for the purpose of determining your eligibility for Donated Leave. Persons outside of the Department of Human Resources will not have access to this information.

Please return completed form to:

Mississippi University for Women
Human Resources ATTN: Donated Leave
1100 College ST, MUW-1609
Columbus, MS 39701-5800
Or Fax to: Human Resources, ATTN: Donated Leave 662.241.7616

PART IV – HUMAN RESOURCES VERIFICATION

Applicant is:

☐ **ELIGIBLE** to receive donated leave.
☐ **NOT ELIGIBLE** to receive donated leave.

First Day Donated Leave Used: _____
HR Verification Signature: _____ Date: _____
Title: _____