DONATED SICK LEAVE PROGRAM

Donor Certification

Name of Employee _____ **Employee ID** _____

FTE (1.0, .75, .50) _____ **Phone** _____

Department _____ **GT Email** _____

INSTRUCTIONS: Please return this form to:

Director, Benefits
Georgia Tech Human Resources
500 Tech Parkway
Atlanta, GA 30332

Mark as private and confidential.

Georgia Tech Human Resources

Donated Sick Leave Program

Recipient Affidavit
Donated Sick Leave Request Form

I request to use hours from the Donated Sick Leave Program under the terms specified in the Georgia Tech Donated Sick Leave Program description, and with the understanding that the specific nature of my/my spouse's/my child's illness will be kept in confidence.

Name of Recipient _____ **Employee ID** _____

Department Code _____ **Mail Code** _____

Email _____ **Phone** _____

Date Qualifying Condition Began _____ **Date Qualifying Condition Ended or Is Expected to End** _____

Number of Donated Sick Leave Hours Requested _____ **Date to Begin Use of Donated Sick Leave Hours** _____

I am submitting herewith medical verification (Physician's Certification Form) which confirms a serious medical condition as described in the Georgia Tech Donated Sick Leave Program policy.

I certify that the above information is true and complete to the best of my knowledge.

_____ _____

Signature of Recipient or Authorized Recipient Representative **Date**

_____

Printed Name of Authorized Recipient Representative

_____ _____

Signature of Supervisor **Date**

_____ _____

Printed Name of Supervisor, Department and Title **Date**

Georgia Tech Human Resources

Donated Sick Leave Program

Physician's Certification Form

Part A. To Be Completed by the Employee

Employee Name	Employee ID	FTE (1.0, .75, .50)	Phone

Department/Mail Code	Street Address, City, State, Zip Code

Part B. To Be Completed by the Physician

Definition: Serious medical condition means a health condition involving a serious illness, injury, impairment, or condition that is likely to require the employee's absence from work for an extended period of time longer than the amount of sick and annual leave available to the employee, and the health condition is such that it is not medically appropriate for the employee to delay the absence in order to accrue additional sick or annual leave prior to the absence. Some examples of such conditions include: advanced or rapidly growing cancers, acute serious illnesses, chronic life-threatening conditions involving failure of bodily organs or systems (e.g., heart attack) or chronic conditions requiring extended rehabilitation such as back surgery. The absence may be continuous, as in hospitalization following surgery or an accident, or intermittent, as in periodic absences for chemotherapy or other procedures.

(Attach additional sheet if more space is needed).

In your opinion, does the employee (or spouse or child) meet the "serious medical condition" definition as described above?

Check One: **YES** ☐ **NO** ☐

Date patient was first unable to work _____

Diagnosis description _____

Has the patient been hospital confined?

Check One: **YES** ☐ **NO** ☐

If yes, provide hospital name and admittance date _____

Prognosis (possible duration of condition) _____

When could patient resume work? (List any restrictions to regular duty). _____

Physician's Certification Form – page 2

Physician's Name:

(Please Print)	Specialization

Street Address, City, State, Zip Code

Physician's Signature (please do not use stamp)	Date

Part C. To Be Completed by the Employee or Person Acting on Behalf of the Employee

I understand that the information requested on this Physician's Certification of Emergency or Life Threatening Medical Condition Form is for the use of determining my eligibility to participate in the Donated Sick Leave Program at the Georgia Institute of Technology. Failure to provide all the requested information will result in my request not being processed or approved by the Donated Sick Leave Certification Committee. Further, I am aware that any medical information provided will remain in confidence.

Employee Patient Signature	Date
Printed Name of Person Acting on Behalf of Employee Patient	Date
Signature of Person Acting on Behalf of Employee Patient	Date

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500 Tech Parkway
Atlanta, GA 30332

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Donated Sick Leave Program Confidentiality Agreement

I, _____, understand that my participation as a member of or interaction with the Georgia Tech Donated Sick Leave Certification committee will involve reviewing sensitive personal and medical information about employees or employee family members. This information includes but is not limited to: verbal or written information derived from a health care provider regarding medical history, mental, or physical condition or treatment, as well as employee and/or heir family members' records, test results, conversations, and research records.

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, and any other conversations regarding specific employees or their family members which are generated in connection with my responsibilities for the Georgia Tech Donated Sick Leave Certification committee.

2. I shall protect the privacy, confidentiality and security of all employee or employee family member medical information received in conjunction with an employee's request to receive shared leave.

3. I agree to discuss sensitive medical information only with members of the Georgia Tech Leave Donation Certification committee or Program Administrator, only in the work place, and only for the necessary purposes of discussing an employee's eligibility to receive shared leave. I will not discuss such information outside of the work place or within hearing of other people who do not have a need to know about the information.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of this Confidentiality Agreement, I acknowledge that the Georgia Institute of Technology may, as applicable and as it deems appropriate, pursue disciplinary action.

_____ _____

Signature **Date**

_____

Print Name

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Atlanta, GA 30332

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