REQUEST TO RECEIVE DONATED VACATION LEAVE

(Complete and submit to the Catastrophic Leave Sharing Program, L-640 or fax to ext. 28287)

_____	_____	_____	_____
Recipient Employee Name:	Emp. No.	Wk. Phone:	Home Phone:
_____	_____		_____
Payroll Acct.	Supervisor Name:		Phone:

I am requesting donated vacation due to the following qualifying event (check one):

[ ] My serious illness, injury or incapacitating condition. (Please attach Doctor's Certification form indicating the date you became unable to perform your job and the expected duration. Such certification should not reveal or describe the specifics of any medical or mental condition or symptom.)

[ ] Personal hardship due to the serious illness, injury, or incapacitating condition of my spouse, parent, child, sibling, grandparent or grandchild; in laws or step-relatives in these relationships; or other person residing in my household for whom there is a personal obligation. My signature below signifies that there exists no other reasonable alternative care other than my own, which would not create a hardship on me. (Please attach Doctor's Certification form of the date your eligible family member's serious illness, injury, or incapacitating condition began and the expected duration. Such certification should not reveal or describe the specifics of any medical or mental condition or symptom.)

I estimate I will require _____ days of donated vacation during this Catastrophic Leave period.

I authorize □ /(I do not authorize □) release of my name and the number of days of donated leave I am requesting be placed on the LLNL Benefits Office website (viewable internally and externally) in soliciting donors for this request.

I understand that receipt of any donated vacation is subject to my eligibility and its availability. I also understand that use of donated leave is allowed only during the period of the above indicated illness or injury and that I will be responsible for promptly notifying payroll of the termination of such condition. Unused donated leave will be forfeited upon the earlier of, conclusion of this leave or separation from employment.

_____ _____

Recipient Employee Signature Date

Official Use:

Authorized to receive up to _____ hours donated leave: effective date _____

_____ _____

Human Resources Representative Date

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