

APPLICATION FOR LEAVE SHARING PROGRAM

Please direct all completed applications and questions to:

Jayna Davis, Leave Sharing Chairperson
Davisjg@colorado.edu
303-735-5933, 303-492-4491 (FAX)

Employee Relations, 565 UCB
3100 Marine St., 3rd Floor
Boulder CO 80309-0565

Leave Sharing Application Instructions

The Leave Sharing Committee “the Committee” reviews applications on a monthly basis, on the first Tuesday of each month. Completed applications should be submitted no later than one week prior to the Committee review meeting date. At the discretion of the Committee, meetings may be rescheduled or canceled.

The Committee is unable to evaluate an employee’s application for leave sharing until all documents have been properly completed and returned to the department HR Liaisons (who will then send to the Leave Sharing Chairperson).

Employee Eligibility

University of Colorado at Boulder and System Administration employees who have a minimum of one year of State service or University of Colorado employment are eligible to apply for leave sharing hours.

Applicant Responsibility:

- Provide a personal statement.
- Complete Part I of the application.
- Have healthcare provider (for medical conditions) complete Part IV of the application, as well as the FMLA medical certification.
- Forward completed materials to department HR Liaison.

When Short-term disability applies, leave sharing hours may only be awarded for any unpaid portion of the waiting period, typically 30 days, leading up to when short-term disability benefits would commence. University Staff and faculty on 12-month appointments who have opted not to purchase short-term disability coverage and are requesting leave sharing for their own condition may only use leave sharing hours to cover what would have been the unpaid portion of the waiting period had they purchased coverage.

HR Liaison Responsibility:

- Complete Part II of the application.
- Have the department Appointing Authority complete Part III of the application.
- Gather leave records for current and previous fiscal year.
- Collect all leave sharing documents required for the application process.
- Once the HR Liaison has received all documents from the applicant and Appointing Authority, they should compile into a single document in the following order –
 - personal statement, parts I-IV of the application, FMLA medical certification, and leave records
- Forward the complete application to the Leave Sharing Committee Chairperson.

Retroactive leave sharing awards are processed in the form of a hand-drawn check. For such awards, ensure that the applicant was returned to paid leave status for the appropriate time period so that leave accruals are tracked accurately.

Appointing Authority Responsibility:

- Review applicant leave records for the current and previous fiscal years.
- Complete Part III of the application and return to HR Liaison.

If the Appointing Authority endorses a leave sharing application, the Committee will evaluate the applicant’s eligibility for leave sharing hours according to the parameters of the policy. If an appointing authority has concerns regarding the applicant or application, please contact the Leave Sharing Chairperson. The Appointing Authority should also be aware that the department is fiscally responsible for any leave sharing hours awarded.

Please refer to the Leave Sharing policy and FAQs for more detailed information, or contact the Committee Chairperson directly.

Thank you for your cooperation.

PART I - Completed by Applicant:

Check one:

Classified Employee University Staff

Instr. Faculty on 12 mo. appointment Research Faculty on 12 mo. grant-funded appointment

Check one:

UCB employee System Administration employee

Name _____ Employee ID # _____

Department _____

Work Phone _____ Job Title/Classification _____

Email Address _____

University Hire Date _____ Current % of FTE _____

Home Address: Street _____

City, State and Zip _____

Home Telephone _____

Request is for care of: Self Family Member Other _____
(Specify)

Anticipated duration of applicant's absence from work: _____

Start date _____ Estimated return date _____

Number of leave sharing hours requested _____

Complete all that apply:

Date FMLA applied for (attach medical certification) _____ Approval date _____

Date Short-Term Disability applied for _____ Approval date _____

Date Worker's Compensation applied for _____ Approval date _____

Date PERA Disability/Retirement applied for _____ Approval date _____

Date Long -Term Disability/Retirement applied for _____ Approval date _____

I hereby certify that I understand, agree to, and meet the requirements of the Leave Sharing Program. I understand that any decisions made with respect to this application are not subject to grievance or appeal.

Signature of Employee

Date

Please refer to the Leave Sharing policy and FAQs for more detailed information, or contact the Committee Chairperson directly.
Thank you for your cooperation.

PART II - Completed by Applicant's HCM community member (formally Payroll & Personnel Liaison):

Name: _____

Telephone Number: _____ Email Address: _____

Please answer the following question:

1. Has this employee exhausted all sick and annual/vacation leave and compensatory time? Yes No

a. If YES, when was leave/comp time exhausted? _____

If NO, as of _____ (insert date), applicant has:

_____ hours of annual/vacation leave _____ hours of sick leave _____ hours of compensatory time.

NOTE: Retro-awards are processed in the form of a hand-drawn check. For such awards, ensure that applicant was returned to paid leave status for appropriate time period so that leave accruals are tracked accurately.

My signature below indicates that I have attached copies of the applicant's annual leave record forms for the current and prior fiscal year, and understand that if this application is approved, I am responsible for making the adjustments into the HRMS system and department records. I agree to accurately track leave sharing hours so that such hours are only used in connection with the condition stated in this application.

Signature of HCM community member

Date

PART III- Completed by Applicant's Appointing Authority (or Supervisor for Research Faculty): Please review leave records for the current and previous fiscal year before providing the following information.

Appointing Authority (Supervisor) Name: _____

Appointing Authority (Supervisor) Title: _____

Telephone Number: _____ Campus Box: _____

Please answer the following question:

1. If, upon review of this application, you chose to deny Appointing Authority approval, please detail the reasoning below. (It is advised to retain this application within the departmental medical personnel file)

NOTE: If the Appointing Authority endorses a leave sharing application, the Committee will evaluate the applicant's need for leave sharing hours according to the parameters of the policy.

My signature below indicates that I approve this application and understand that my department is fiscally responsible for any hours awarded to this employee and that any hours awarded are to only be used in connection with the condition stated in this application.

Signature of Appointing Authority (or Supervisor for Research Faculty)

Date

Please refer to the Leave Sharing policy and FAQs for more detailed information, or contact the Committee Chairperson directly.
Thank you for your cooperation.

PART IV - Completed by Attending Healthcare Provider for Applicant or Applicant's Family Member:

Healthcare Provider's Name _____ Telephone _____

Address: Street _____

City, State and Zip _____

Please review Genetic Information Non-Discrimination Act (GINA) Disclosures on the next page and then provide detailed responses to the following questions:

1. What is the patient's illness/injury?_
2. When was the illness/injury diagnosed? _____
3. Does the illness/injury pose a direct threat to the patient's life?

Yes (and check all that apply):

The patient's illness/injury itself is life-threatening .

A medical procedure the patient had/has to undergo as a result of the illness/injury is life-threatening.

The patient suffered a life-threatening complication as a result of his/her illness/injury or a medical procedure that he/she had to undergo.

If the patient does not seek immediate treatment, his/her condition will become life-threatening.

No (please explain):

4. Will/did the patient's illness/injury require inpatient, outpatient, hospice or residential care (either at a facility or in patient's home)?

Yes

No

Please Explain:

5. Will/did the patient experience a period of "incapacity" of 30 consecutive days or more due to his/her condition? (*"Incapacity" means that the patient is substantially limited in performing activities in his/her daily life which he/she can normally perform. For example, the patient is substantially limited in seeing, speaking, hearing, breathing, sitting, standing, walking, lifting, reading, learning, performing cognitive tasks, feeding, bathing, dressing or grooming him/herself.*)

Yes

No

Please Explain:

6. If the employee will be providing care for the patient, what is the type and frequency of care needed?

Signature of Healthcare Provider

Date

**Please refer to the Leave Sharing policy and FAQs for more detailed information, or contact the Committee Chairperson directly.
Thank you for your cooperation.**

Attention Applicants: This page must be provided to the applicant or applicant's family member's attending healthcare provider along with PART IV (page 4 of 5) of the application.

Genetic Information Nondiscrimination Act of 2008 (GINA) Disclosure Statement

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. However, please be advised that GINA Title II does allow you to provide information about the medical condition of an employee's spouse, parent, child, legal dependant or person in the home for whom they are a primary caregiver, in order to substantiate the need for leave under CU-Boulder's leave sharing program.

**Please refer to the Leave Sharing policy and FAQs for more detailed information, or contact the Committee Chairperson directly.
Thank you for your cooperation.**