PROFESSIONAL / SUPPORT STAFF
VOLUNTARY TRANSFER OF
ACCRUED ANNUAL OR SICK LEAVE

The District recognizes the existence of circumstances under which non-job-related, seriously incapacitating, and extended illnesses and injury may exhaust accrued leave of employees. To provide some measure of relief in such situations, a limited mechanism, based upon voluntary transfer of accrued annual or sick leave, is established. The mechanism will be termed transfer of accrued annual or sick leave for a medical emergency. The definition of a 'medical emergency' will be as follows: A medical condition of the employee or a family member of the employee that will require the prolonged absence of the employee from duty and will result in a substantial loss of income to the employee because the employee will have exhausted all paid leave available apart from the leave-sharing plan.

Limits to Donations:

- The donated leave will be limited to annual leave or sick leave (sick leave will be any paid leave that the district, by policy, allows to be used for that purpose).

- Donations will be limited by organizational structure to prevent undue influence and conflict of interest issues. *

  - Employees who are licensed (certificated) professional educators shall be limited to donating leave for use by those who are licensed (certificated) professional educators.

  - Other employees (support staff) shall be limited to donating leave for use by other support staff.

  - Central office and building level professional staff supervisory personnel may only donate to other professional staff supervisory employees.

- The person donating may only donate already accrued leave up to twenty (20) days and shall maintain in accrued leave at least twenty-eight (28) days of sick leave (or the equivalent) at the time of the donation. *

- Donations will be by accrued days of leave, using either the donor's current daily wages or hourly wages earned for each donated day. The recipient shall receive the the donation converted to the daily wages they currently earn.

- All donations shall be for the current contract year and shall not exceed that period based upon the current contract earnings of the person to whom the donation is made. *

- All donations shall be on behalf of a specific recipient with the donation made to the district plan for transfer of leave based upon a medical emergency.

- All unused donated leave shall revert to the donating employees on a prorated basis.

Notice and receipt of donations.

- Notice of need for leave donations will be posted by need for licensed professional staff, central office and building level professional supervisory staff, and support staff including the name of the individual. (*)

- Posting will be by placing the notice of need at the central office, and by the mailboxes used for staff members of the district.

- Forms will be provided on which employees may make their donations known to the district office.

Eligibility (for use of transferred leave). The approved applicant shall:

- Be a full-time employee (an employee eligible to earn sick leave).

- Have a "medical emergency" as defined in this policy.

- Have exhausted all earned/accrued leave of any nature or kind including compensatory time and be eligible for an unpaid leave of absence.

- Not be eligible at the time of request for disability benefits, including but not limited to Social Security.

- Be one whose return to duty is projected to occur no later than the beginning of their next contract year. *

- Submit an application, which shall be received by the District office at least ten (10) days prior to the beginning of the applicant's unpaid leave status, when practicable.

Determining eligibility:

- The Superintendent shall appoint an advisory committee consisting of at a minimum, one health education professional, one support staff member, one licensed teacher and one professional supervisory person to review the applications and make a recommendation to the Superintendent.

- The Superintendent shall receive the applications and make the final determination of eligibility using the criterion of eligibility and in consideration of the recommendation of the advisory committee.

No continuing rights are established by this policy. In compliance with established procedure, the Governing Board reserves the right to modify, change, or delete any policy in accord with its own guidelines. An appeal of the decision of the Superintendent may only be taken using the Staff Grievance Policy GBK.

Adopted: date of manual adoption

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(Application Screening)

The application must be in writing.

The application must be supported by a certified document by a health care provider that describes the nature, severity, and anticipated duration of the emergency medical condition of the recipient and that includes a statement that the recipient is unable to work all or a portion of the recipient's work hours.

The application should be received by the District office prior to the applicant beginning unpaid leave status.

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(Application Screening Committee)

A committee consisting of at a minimum one health education professional, one licensed teacher, one support staff member, and one professional supervisory person as appointed by the Superintendent are to review the applications and make a recommendation to the Superintendent who will approve or deny the leave. The applications are to be reviewed in accord with the guidelines found in policy and as presented below:

The approved applicant shall:

- Be a full-time employee (an employee eligible to earn sick leave).
- Have a "medical emergency" as defined in this policy.
- Have exhausted all earned/accrued leave of any nature or kind including compensatory time and be eligible for an unpaid leave of absence.
- Not be eligible for disability benefits, including but not limited to Social Security.
- Be one whose return to duty is projected to occur no later than the beginning of their next contract year. *
- Submit an application, which shall be received by the District office at least ten (10) days prior to the beginning of the applicant's unpaid leave status, when practicable.

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TRANSFER OF LEAVE REQUEST FORM

Name ____

Date of Application ____________________________________

Mailing Address ____
Street or Box Number City State Zip

( ) ______________ ______________ ______________
Home Phone Number Work Location Job Title

Submit this request form to the Superintendent of Schools at least ten (10) days before the leave is to commence, when practicable. Use of the transferred leave counts towards The Family and Medical Leave Act (FMLA) leave used by employees.

For determination of eligibility, please answer each of the following questions. Put an (x) in the appropriate response column.

YES	**NO**	
		Is this your first claim for this particular condition?
		Have you exhausted all earned/accrued leave of any nature or kind including compensatory time?
		Have you attached to this application a signed STATEMENT OF A HEALTH CARE PROFESSIONAL verifying this condition?

By my signature below I give permission to the District to use my name and employment information in requesting transfer of leave donations.

In addition to the statement provided by my health care professional, I also agree to submit to an examination by a health care provider of the School Board's choice, if requested to do so, at the school District's expense.

____
Employee Signature

____
Administrator Signature if Employee unable to sign

DATES OF TRANSFERRED LEAVE REQUESTED

I request leave from ______________________ to ______________________

I request a reduced schedule on the following dates ______________________

____

I request intermittent leave according to the following schedule ____________

____

____

____

The total number of days of Transferred Leave that I request is ___________

EMPLOYEE STATEMENT

I agree to return to work on __________________. If circumstances change such that I will not be able to return to work on that date, I agree to notify my supervisor within two (2) days with updated leave information and will submit an updated health care professional's statement to the Leave Administrator.

Signature ____________________________________ Date ______________

TO BE COMPLETED BY THE TRANSFER LEAVE ADMINISTRATOR

Prior transfer leave request confirmed by date ________________________

Leave is ☐ Approved ☐ Denied for the following reason(s):

____ ____________________

Administrator Signature Date

PROFESSIONAL / SUPPORT STAFF
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EMPLOYEE TRANSFER LEAVE PROGRAM
STATEMENT OF HEALTH CARE PROFESSIONAL

After completing this form, please send to:
Hobbs Municipal Schools
Human Resources Department
1515 E. Sanger
Hobbs NM 88240

Name of Patient ____
Last First MI

If the patient is not an employee of the District above
what is the relationship to the employee ______________________________

Please answer the following questions (attach additional pages if necessary):

1. Describe the nature of the illness/injury (diagnosis) ________________

2. State the approximate date the illness/injury commenced, and the probable duration of the illness/injury (and also the probable duration of the patient's present incapacity, if different).

____

3. Will it be necessary for the patient to be on an intermittent or a less than full schedule as a result of the illness/injury (including for treatment described in item 6 below)?

Yes _____ No _____

If yes, give the estimated date of return to full-time work
or a normal schedule. ______________________________________

4. If the patient will be absent from a full schedule because of treatment of the illness/injury on an intermittent or part-time basis, provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any.

____

5. If any of these treatments will be provided by another provider of health services (e.g. physical therapist), please state the nature of the treatments.

____

6. Is it necessary for the patient to be absent from work for treatment?

Yes _____ No _____

7. What is the date you first required the patient to begin treatment
for the illness or injury? ______________________________________

This is to certify that this patient has suffered a medical condition that will require the patient to take a prolonged absence from performing his/her normal duties or in the alternative requires a family member of the patient as care taker to take a prolonged absence from their duties to assist in the care of the patient during treatment and recovery.

_______________________________ _______________________________
Health Care Provider Signature Name (please print)

__________ ____
Date Street or Box Address City State ZIP

Telephone Number ____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Patient ____
Last First MI

I authorize the use or disclosure of the above individual's health information as described in this form.

The following Physician or Physician's office is authorized to make the disclosure.

____

____

Address ____

Specifically describe the illness or injury to be used or disclosed.

____

This information may be disclosed to and used by the following individual or organization for the purpose of providing leave transfer:

Hobbs Municipal Schools

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to:

TJ Parks

I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authorization will expire on the following date ______________ event ______________________ condition ______________________

If no expiration date, event or condition is specified, this authorization will expire in six (6) months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. If I have questions about disclosure of my health information, I can contact the Superintendent of Schools.

____ ______________________

Signature of Employee Date

PROFESSIONAL / SUPPORT STAFF
VOLUNTARY TRANSFER OF
ACCRUED ANNUAL OR SICK LEAVE

REQUEST TO DONATE ANNUAL OR SICK LEAVE

Name ____

Date of Application ____

Mailing Address ____
Street or Box Number City State Zip

( ) ____________________ ______________________ _____________________
Home Phone Number Work Location Job Title

I request that annual or sick leave be transferred to the leave account of an approved leave recipient (name) [_____________________________} under the Transfer of Annual or Sick Leave Policy of this District.

As of the date indicated below I have enough leave accrued to my account to cover the transfer request in accord with the requirements of the District Policy. The amount of annual and sick leave I am transferring also does not reduce my accrued leave below that allowed by policy.

I understand that my decision to transfer leave is not revocable. If a sufficient balance of unused leave remains after the recipient's medical emergency has terminated, I will have a pro-rated share returned to me during either the current leave year or the following leave year.

I have not been directly or indirectly intimidated, threatened or coerce, or promised any benefit by any employee for the purpose of donating or using leave.

Conditions and Limitations to Donations:

- The donated leave will be limited to annual leave or sick leave (sick leave will be any paid leave that the District, by policy, allows to be used for that purpose).
- Donations will be limited by organizational structure and to prevent undue influence and conflict of interest issues. *****
    - Employees who are licensed (certificated) professional educators shall be limited to donating leave for use by those who are licensed (certificated) professional educators.
    - Other employees (support staff) shall be limited to donating leave for use by other support staff.
    - Central office and building level professional staff supervisory personnel may only donate to other professional staff supervisory employees.
- The person donating may only donate already accrued leave and shall maintain in accrued leave at least twenty-eight (28) days of sick leave (or the equivalent) at the time of the donation. *****

- Donations will be by accrued days of leave, using either the donor's current daily wages or hourly wages earned for each donated day. The recipient shall receive the donation converted to the daily wages they currently earn.

- All donations shall be for the then current contract year and shall not exceed that period based upon the current contract earnings of the person to whom the donation is made. *

- All donations shall be on behalf of a specific recipient with the donation made to the district plan for transfer of leave based upon a medical emergency.

- All unused donated leave shall revert to the donating employees on a prorated basis.

____ ____________________

Signature of Employee Date