**COLORADO COMMUNITY COLLEGE SYSTEM**

**CLASSIFIED EMPLOYEES'**

**ANNUAL LEAVE DIRECT TRANSFER PROGRAM**

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PURPOSE

To establish a means to voluntarily transfer annual leave to a qualifying classified employee experiencing a catastrophic medical hardship, such as cancer, major surgery, serious accident, heart attack, etc., either personally or by an immediate family member that requires inpatient, hospice or resident health care. This program provides some income protection when the employee would be absent from work for a prolonged period of time.

APPLICATION FOR LEAVE

The *Application For Use Of Transferred Leave* form must be completed by the requesting classified employee and submitted to the Human Resources Office for verification. Application may be made for personal or immediate family member need. For purposes of the leave transfer program for family members, preference will be given to a child, parent or spouse requiring the employee's direct care. Human Resources will complete their section and forward to the employee's supervisor and college president for final approval

In order to use donated leave, the employee must first exhaust all sick leave (as permitted under BP3-60) and must not be receiving salary replacement benefits from worker’s compensation, short-term disability or long-term disability. It is not intended to cover cases of abusive leave usage. Approval or disapproval will be based on the merits of each individual case and the following guidelines:

* Application can be made for either personal use or for the care of an immediate family member.
* Applicants must have one year of service before applying for use of transferred leave.
* Applicants must have exhausted all annual and sick leave.
* Requests must be made for reasons of catastrophic illness or injury. Normal pregnancy, common illness, coverage by Worker's Compensation, or PERA disability are excluded.
* Application does not constitute automatic approval of the request.
* If approved, the granted leave is meant to cover only the duration of the illness/injury for which it was collected.
* Performance, length of service, and leave usage patterns may be considered in the decision to grant or deny the application.
* All or a portion of the time requested may be granted.
* The decision to approve or deny the application is final and not subject to grievance or appeal.
* In cases where the situation ceases to exist or the employee terminates or retires, any unused portion of the collected leave will be refunded to donors.
* Awarded time may be applied retroactively to the beginning of the leave-without-pay period for the illness/injury for which it was granted.
* State rules and procedures which apply to paid leave apply to use of awarded time except that it is not part of the final pay-out for retirement or termination.

CONTRIBUTIONS

Contributions must be made from accrued annual leave and is credited to the recipient on an hour-for- hour basis. A minimum donation of two hours of accrued annual leave is required. The employee is encouraged to keep some balance for his/her own use.

Contributions are voluntary and confidential and will no longer be accepted when the amount needed has been received. When more contributions are available than needed, donors will receive a proportionate refund (number of extra hours/number of donors).

INSTRUCTIONS

1. Applications must be made in writing on the *Application For Use Of Transferred Leave* form (see page 4).

2. Supporting documents to accompany the application may include records of performance and leave usage. Performance, leave usage patterns, and length of service may be considered in the decision. Letters of support may also be included.

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Application For Use Of Transferred Leave

**Part I - To be completed by the classified employee (please type or print legibly in ink).**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee S# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address/City/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Unit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full Time \_\_\_\_\_\_ Part Time \_\_\_\_\_ % Appt\_\_\_\_\_\_

I hereby certify that I understand, agree to, and meet the requirements and conditions of the leave transfer program. I also hereby authorize the College President or his/her designee to obtain any necessary information concerning this application. I understand that denial of this application is not subject to grievance or appeal.

Signature of Employee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part II - To be completed by Human Resources.**

Date Benefit Eligible Employment began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Salary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has employee requested/applied for: Worker's Comp \_\_\_\_ FMLA\_\_\_\_\_ LTD\_\_\_\_\_ PERA Disability\_\_\_\_\_\_

Is Medical Certification verifying catastrophic illness on file? Yes \_\_\_\_\_ No\_\_\_\_\_

Date illness/injury began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anticipated duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date all sick leave will be/was exhausted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of days needed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Human Resources\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part III - To be completed by Supervisor/President.**

Authorization to request donated leave is:

*Approved Denied* Signature of Supervisor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Approved Denied* Signature of President\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Leave Contribution Record

Please type or print legibly in ink.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee S#\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first) (last)

Full Time \_\_\_ Part Time \_\_\_ % Appt \_\_\_\_ Job Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Unit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of hours donated \_\_\_\_\_\_\_\_\_\_\_\_\_\_ To (Employee/Case #): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my contribution is voluntary and that my balance of annual leave will be decreased by the amount contributed. I certify that my contribution will not result in a negative leave balance. I understand that my contribution is confidential.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For College/HR Use:

The above named employee's leave balance has been reduced by \_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours of annual leave.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Authorized College/HR Signature) (Date)