DONATED LEAVE APPLICATION INSTRUCTIONS

PLEASE FOLLOW THE INSTRUCTIONS BELOW TO COMPLETE THE DONATED LEAVE APPLICATION PROCESS

1. Applicant must complete the attached Donated Leave application and have it signed by his/her immediate supervisor.

2. Applicant must submit a doctor's note so that we may verify that the applicant (or immediate family member) has been diagnosed with a catastrophic illness or injury or will be out of the office for at least 60 work days.

3. Applicant must submit verification that a total of at least five sick or vacation days will be donated. To do this, please have an employee or employees complete Donated Leave Transfer forms attached.

4. Applicant must submit the attached memo signed by his/her office manager stating that the he/she has not been disciplined for chronic or excessive absenteeism, chronic or excessive lateness, or abuse of leave within the last two years.

5. Applicant must complete and sign a Recipient Affidavit.

ALL COMPLETED APPLICATIONS CAN BE SUBMITTED VIA FAX TO THE PAYROLL OFFICE AT (609) 633-6829 OR VIA INTEROFFICE MAIL TO THE PAYROLL OFFICE AT CC941 OR VIA REGULAR MAIL AT:

DEPARTMENT OF CHILDREN AND FAMILIES
PAYROLL UNIT CC 941
50 E. STATE ST.
PO. BOX 717
TRENTON, NJ 08625-0717

If you have any questions please contact the payroll unit at 1-877-382-8718 ext.7826.

STATE OF NEW JERSEY
DEPARTMENT OF CHILDREN AND FAMILIES
Po Box 717
Trenton, NJ 08625-0717

DONATED LEAVE APPLICATION

APPLICANT INFORMATION

NAME : (LAST) _____ **(FIRST)** _____ **(M.I.)** _____ **(SS #)** __ __ __- __ __- __ __ __ __

ADDRESS: (NUMBER) _____ **(STREET)** _____ **(CITY)** _____ **(STATE)** _____ **(ZIP)** _____

TELEPHONE #: (HOME) _____ **(ALTERNATE)** _____

OFFICE INFORMATION

LOCATION: (OFFICE NAME) _____ **(COST CODE)** _____ **(OFFICE TELEPHONE #)** _____

SUPERVISOR: (NAME) _____ **(SUPERVISOR TELEPHONE #)** _____

TIMEKEEPER: (NAME) _____ **(TIMEKEEPER TELEPHONE #)** _____

SIGNATURES

APPLICANT: (PRINT NAME) _____ **(SIGNATURE)** _____ **(DATE)** _____

SUPERVISOR: (PRINT NAME) _____ **(SIGNATURE)** _____ **(DATE)** _____

Department of Children and Families

Donated Leave Program

Recipient Affidavit

1. I have read the procedures regarding the donated leave program and I wish to participate in this program. I understand that by participating I consent to have my name posted on bulletin boards, or posted by other appropriate means in order to identify donors.

2. I certify that I have not offered anything of value to any employee in exchange for the donation of paid leave time.

3. I have not directly or indirectly intimidated, threatened, coerced, or attempted to intimidate threaten or coerce any employee to obtain donated leave.

4. I have not interfered with any right which another employee may have with respect to contributing, receiving or using paid leave under this program.

5. I understand that I cannot receive temporary disability (TDI) benefits for the same periods that I am paid wages from donated sick and/or vacation leave or while using any of my own paid leave time.

6. I also understand that the Temporary Disability Benefits Law requires that I use all of the donated sick leave before benefits can be paid.

_____ _____

(Print Name) **(Signature)**

_____ _____

(Social Security Number) **(Home Telephone Number)**

_____

(Date)

State of New Jersey
DEPARTMENT OF CHILDREN AND FAMILIES
PO BOX 717
TRENTON, NJ 08625-0717

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Commissioner

RE: DONATED LEAVE

I, _____, hereby certify that _____, has
(MANAGER) **(APPLICANT)**
not been disciplined for chronic or excessive absenteeism, chronic or excessive lateness, or abuse of leave within the last two years.

_____ _____
(MANAGER NAME PRINTED) **(MANAGER SIGNATURE)** **(DATE)**

DEPARTMENT OF CHILDREN AND FAMILIES
DONATED LEAVE TRANSFER FORM

Please return completed form to The Office of Human Resources, cost code 941.

I hereby request the Appointing Authority to transfer my leave credit as indicated below to be used as the recipient's personal sick leave.

DONATION SECTION

RECIPIENT: (Name) _____
I wish to donate _____SICK DAYS. This will not reduce my sick leave balance below 20 accrued sick days. _____
(**SIGNATURE)**
I wish to donate _____VACATION DAYS. This will not reduce my vacation leave balance below 12 accrued vacation days. _____
(SIGNATURE)

CERTIFICATION SECTION

I certify that I have not solicited or accepted anything of value in exchange for the donation of paid leave time. I certify that I have not, directly or indirectly, been intimidated, threatened or coerced into donating this time.

(DATE) (PRINT NAME) (SIGNATURE)

DIVISION/INSTITUTION_____COST CODE _____

ADDRESS_____OFFICE PHONE_____

RETURN TO: (The Office of Human Resources)

TO BE COMPLETED BY THE OFFICE OF HUMAN RESOURCES

_____ Your request to transfer the above sick and/or vacation day(s) has been approved.

This is to advise you that your sick and or vacation days will not be transferred due to the following reason:

_____ Employee has not received the minimum number (5) of donated days.
_____ Employee has already received the maximum number of 180 donated days.
_____ Your current sick leave balance does not show the required minimum number of 20 accrued days.
_____ Your current vacation leave balance does not show the required minimum number of 12 accrued days.

_____ _____
HUMAN RESOURCE OFFICER'S SIGNATURE **DATE**

Updated 1/5/12