



Compassionate Leave Verification Form

Employee requesting eligibility to receive Compassionate Leave donations: Complete the following and return to Human Resources.

Name of Receiving Employee	Receiving Employee USNH ID	Campus Telephone Number
Receiving Employee's Department/Dept. Address		Donor Employment Status (OS, PAT, FY Faculty)

I understand I may be eligible to receive compassionate leave donations if all of the conditions below apply:

- I have submitted a completed Certification of Physician form to the Office of Human Resources, and it has been approved as Family and Medical Leave.
- My medical care provider certifies that I have a serious health condition, which will extend for a minimum of 30 calendar days.
- I have exhausted, or expect to exhaust, all earned time or vacation time, sick leave/sick pool and compensatory time; and must be facing a minimum of five days of unpaid leave. (I may be eligible to receive compassionate leave to care for a family member; even though I have, sick leave/sick pool balance).
- The total number of received days has not exceeded 20 working days in the 12-month period immediately preceding the receipt of this compassionate leave.
- I expect to return to work for a period of at least 30 calendar days following the leave.

I have verified with Human Resources that my accumulated leave (and compensatory time for Operating Staff) will be exhausted on: _____

Date

The expected dates of my leave are _____ to _____.

I request compassionate leave for a period up to _____ hours (OS) or _____ days (PAT/FY Faculty)

I consent to the written or oral disclosure of my name to eligible donors for compassionate leave purposes

Yes No

Employee's signature _____ Date _____

HUMAN RESOURCES:

I certify that the employee leave balances are as follows:

For OS Earned Time (hours) _____ (date exhausted) _____
 Comp Time (hours) _____ (date exhausted) _____

For Exempt Vacation (days) _____ (date exhausted) _____
(PAT, FY Faculty)

I certify that this employee meets does not meet the recipient leave balance criteria*.

*must exhaust, or expect to exhaust, all earned time/vacation time, sick leave/sick pool, and compensatory time; and must be facing a minimum of five days of unpaid leave related to this absence.

Human Resources authorization, based on leave data certified above:

Approved Not approved ECLS _____ % Time _____ DOH _____

Human Resources Signature

Date