PAID BONE MARROW / ORGAN DONATION LEAVE CERTIFICATION

Name: _____ **Employee Number**: _____

Position: _____ **Department:** _____

Hire Date ***(Month/Day/Year)*****:** _____ **Today's Date** ***(Month/Day/Year)*****:** _____

First Day of Leave: _____ Return Date: _____
(Month/Day/Year) *(Month/Day/Year)*

Reason for Leave:

☐ Bone Marrow Donation (Paid Leave for up to 5 days)

☐ Organ Donation (Paid Leave for up to 30 days)

☐ Organ Donation (Unpaid Leave for up to an additional 30 days)

Physician Certification

I hereby certify that the above identified person is an organ or bone marrow donor and that there is a medical necessity for the donation or the organ or bone marrow.

Physician's Signature _____ *Physician's Phone Number:* _____

Physician's Printed Name _____

- ❑ I understand that I will be required to use up to five days of earned but unused vacation leave for paid bone marrow donation leave.
- ❑ I understand that I will be required to use up to two weeks of earned but unused vacation leave for paid organ donation leave.
- ❑ I understand that during this paid leave entitlement period I will continue to be responsible for my share of payments under the company's group health plan.
- ❑ I understand that during this paid leave entitlement period I will not suffer any break in service, for salary purposes, sick and vacation pay accrual, annual leave or seniority.
- ❑ I understand that this paid leave entitlement period does not run concurrent with any FMLA/CFRA leave I may also be eligible for.
- ❑ I understand that I may be required to provide my employer a doctor's return to work release upon my return.

_____ _____
Employee's Signature Date *(Month/Day/Year)*

Leave is Granted ☐ Leave is Denied ☐

Reason for Denial:

_____

_____ _____
Authorized Signature Date *(Month/Day/Year)*

Distribution: Original to Employee, Copy to Employee Medical Records File