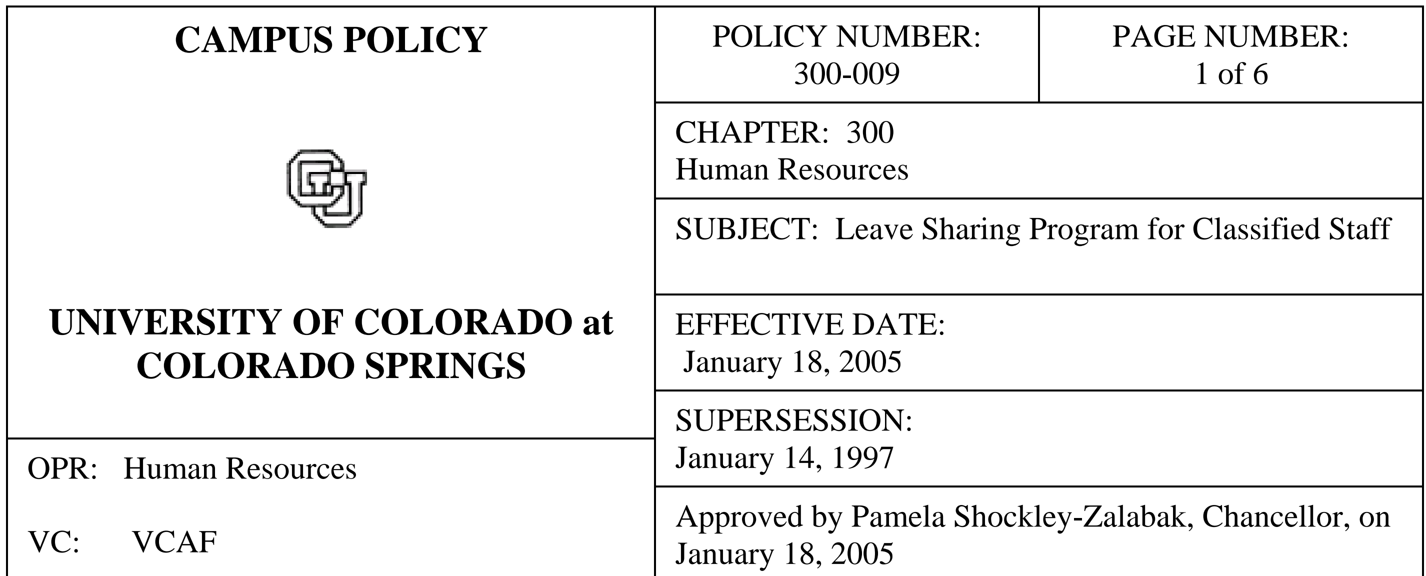

CAMPUS POLICY UNIVERSITY OF COLORADO at COLORADO SPRINGS	POLICY NUMBER: 300-009	PAGE NUMBER: 1 of 6
	CHAPTER: 300 Human Resources	
	SUBJECT: Leave Sharing Program for Classified Staff	
	EFFECTIVE DATE: January 18, 2005	
OPR: Human Resources VC: VCAF	SUPERSESSION: January 14, 1997	
	Approved by Pamela Shockley-Zalabak, Chancellor, on January 18, 2005	

I. POLICY:

A. To establish a means for the transfer of annual leave to a qualifying employee experiencing a catastrophic medical hardship, either personally or by an immediate family member, in order to provide some income protection when the employee would be absent from work for a prolonged period of time and has exhausted all annual and sick leave. This transfer of annual leave may come from one of two sources: direct transfer from one employee or another, or withdrawal from a campus-wide leave bank.

II. AUTHORITY FOR CAMPUS POLICIES:

A. Authority for the creation of campus administrative policies is found in the University of Colorado, Administrative Policy Statements, IV - 49.

B. State Personnel Board Rules and Directors Procedures P-5-12.

III PURPOSE:

A. The purpose of this policy is to provide guidance to classified staff who may have need of leave donated by other UCCS employees, and to those employees who wish to donate their leave to another UCCS employee in need.

IV. DEFINITIONS:

A. Identification of Covered Employees:

This procedure covers all classified staff at the University of Colorado at Colorado Springs (UCCS) who have at least one year of state service.

B. Exclusions: This program is intended to cover serious medical hardship or catastrophic illness or injury, such as cancer, major surgery, serious accident, heart attack, etc., that poses a threat to life and requires inpatient, hospice or resident health care. Normal pregnancy, common illness, and illness/injury covered by short-term disability, PERA or Worker's compensation is excluded. This program is not intended to cover cases of abusive leave usage.

V. PROCEDURE:

A. APPLICATION FOR LEAVE – An employee with a minimum of one year of service is eligible to apply for use of transferred leave. Application may be made for personal or immediate family member need. For purposes of this leave transfer program for family members, preference will be given to a child, parent, or spouse requiring the employee's direct care.

B. The applicant must have exhausted all annual and sick leave before applying for the transferred leave.

C. Applications must be made on the appropriate form provided by the UCCS Personnel Office. The application must be approved by the requesting employee's supervisor and contain the attending physician's statement prior to submission to the Personnel Office. The Personnel Office will verify service eligibility and exhaustion of accrued leave before forwarding it to the Chancellor for a decision.

D. The Chancellor shall approve or deny applications. Decisions are based on the merits of each individual case and the following guidelines.

1). Requests must be for reasons listed under the purpose of this program, e.g., seriousness of the illness/injury, availability of other benefits, exhaustion of leave, etc.
2). In addition to the merits of the case, requests may be denied for suspected sick leave abuse as shown by documentation, incomplete application, refusal to supply information, or ineligibility.
3). Tenure and performance may be considered as documented by performance and employment histories.
4). Application does not require approval of the request. Non-selection is not a determination that the situation is not a personal emergency. It does not prohibit other possible solutions, e.g., leave without pay, etc.
5). The applicant and/or supervisor may be contacted to obtain information regarding the request or invited to present the case.
6). The decision to approve or deny the application is final and not subject to grievance or appeal.
7). Awarded time is not transferable, and is meant to cover only the duration of the illness/injury for which it was requested. In cases where the situation ceases to exist or the employee terminates/retires, any unused portion of the awarded time must be returned to the bank.
8). All or a portion of the time requested may be granted.
9). Awarded time may be applied retroactively to the beginning of the leave without pay for the illness/injury for which it was granted.

10). Personnel rules and procedures which apply to paid leave apply to use of awarded time except that it is not part of the final payout for retirement or termination.

E. CONTRIBUTIONS: Solicitations and donations to the bank shall be during June or when the bank cannot support the need. Additional contributions will be solicited as the need arises. Solicitations will be as anonymous as possible. A minimum donation of one day of accrued annual leave is required. (Employees are encouraged to keep some balance for his/her own use.

1). Contributions may be made only from accrued annual leave. A minimum donation of one half day is required.
2). Contributions are voluntary, confidential and non-refundable.

F. The employee's department is fiscally responsible for the approved leave sharing hours.

VI. RESPONSIBILITY: The Personnel Department is responsible for implementing the provisions in this document.

VII. HISTORY:

VIII. ATTACHMENTS:

1. Request for Use of Transferred Leave form

2. Donation of Annual Leave form

UNIVERSITY OF COLORADO AT COLORADO SPRINGS

APPLICATION FOR USE OF TRANSFERRED LEAVE

PART I – TO BE COMPLETED BY EMPLOYEE (Please type or print legibly in ink)

Name_______________________________________ Social Security #_______________________

Home Address/City/Zip ____

Home Telephone _____________________________ Work Telephone _______________________

Class Title ____

Request is for: Self ________ Child _____________ Parent ____________ Spouse ____________

Are you requesting/applying for: Short-Term Disability _________

Worker's Compensation __________ Disability Retirement ____________

Date illness/injury began ______________________Anticipated duration ___________________

Date all sick and annual leave will be/was exhausted ______________________________________

Number of days requested ____

Briefly describe the nature of illness/injury: ____

____

____

____

____

I hereby certify that I understand, agree to, and meet the requirements and conditions of the leave transfer program. Also, I hereby authorize the Chancellor 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 2 – TO BE COMPLETED BY SUPERVISOR

I hereby certify that, to the best of my knowledge, the above information is accurate. I hereby certify that if the application is granted, authorization to use the leave is granted. Also, I acknowledge that approval of this request commits this department to pay the salary and benefits associated with this leave.

Signature of Supervisor ______________________________ Date __________________________

Part 3—ATTENDING PHYSICIAN'S STATEMENT (Please type or print legibly)

Name ____Telephone Number _______________

Address/City/Zip ____

Date first consulted for this condition ____

Briefly describe the nature, diagnosis, and treatment of illness/injury: ______________________

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____

____

Anticipated duration employee is unable to work due to condition or direct care of family member: From: ____________________________ Through ____________________________

Signature of Physician ____________________________________ Date ____________________

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PART 4—TO BE COMPLETED BY UCCS PERSONNEL OFFICE

The above named employee began permanent classified service on __________________________

works _________________________% time at a monthly salary of $________________________

and will exhaust all annual leave as of ____

Authorized Signature_____________________________________ Date ___________________

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FOR CHANCELLOR USE

Application was received on ______________________________________ and a decision made to ☐ accept or ☐ reject and ______________________________________ days were awarded from the bank. Notification of the decision was sent to the requesting employee and supervisor on ___________________________________.

Authorized Signature: ____________________________________ Date ____________________

Additional Comments:

ANNUAL LEAVE CONTRIBUTION RECORD

Please type or print legibly, in ink.

NAME:____
(last) (first)

SOCIAL SECURITY NUMBER: ____________ - _______________ - _______________

JOB TITLE: ____________________________ WORK PHONE: ____________________

DEPARTMENT: ____

NUMBER OF HOURS TO BE DONATED: _____________________________________

DONATED TO: LEAVE BANK: _____________________________________

INDIVIDUAL: _____________________________________
(print name or solicitation announcement #)

I understand that my contribution is voluntary and that my annual leave balance 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 PERSONNEL OFFICE USE:

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

____ _________________
Personnel Office Representative Date