



HUMAN RESOURCES POLICIES AND PROCEDURES

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Purpose

The Medical Leave Assistance Program is a means by which a **plan member** may donate accrued sick and/or annual leave to a pool or directly to another plan member who is unable to work for an extended period of time. This plan encourages prudent use of accrued leave, but provides access and direct assistance to members with extraordinary medical issues (see life-threatening or emergency medical condition definition below). It can also provide a limited bridge between accrued leave and the University’s short- or long-term disability plan.

Policy

It is the policy of Georgia Southern University to provide a means for University employees to voluntarily contribute sick and annual leave to a leave pool to be used by fellow employees who have exhausted all leave, and because of a medical emergency are in need of additional sick leave.

Definitions

Employee: Any employee of the University who earns or accrues sick or annual leave as a benefit of his/her employment by the University.

Plan member: Any benefitted employee, who voluntarily applies for membership to the Medical Leave Assistance Program, meets the terms and conditions for membership and contributes the required sick and/or annual leave amounts.

Leave donor: An employee making a voluntary written request to transfer sick or annual leave to an account of a leave recipient.

Leave recipient: A current benefitted employee who has completed his/her employment provisional period and for who Human Resources has approved an application to receive leave from the sick or annual leave accounts of one or more leave donors.

Caregiver for an Immediate Family Member: Those individuals who live in the same household as the employee and are related by kinship, adoption, or marriage; or are foster children; and an employee’s minor child regardless of whether the child lives in the same household. If not in the same household, an immediate family member is strictly limited to the employee’s spouse, child or parent. The employee may be eligible for a leave grant when he/she has caregiver responsibilities for an immediate family who has a severe, extraordinary, or life-threatening

illness or injury, and the employee has used or is about to use all of the employee's eligible annual and sick leave.

Service as an Approved Emergency Worker: The employee is serving as an approved emergency worker, and has used or is about to use all of the employee's eligible annual leave.

Called to Duty in a Uniformed Service of the United States: The employee is called to serve in the uniformed services and has used or is about to use all of the employee's eligible annual and paid military leave.

Life-threatening or emergency medical / mental condition: A health condition involving a serious, extreme, or life-threatening illness, impairment, or condition that is likely to require an employee's absence from duty for a period of time longer than the amount of sick and annual leave available to the employee, and the health condition is such that it is not medically appropriate for the employee to delay the absence in order to accrue additional sick or annual leave prior to the absence. The medical condition requires on-going treatment and supervision by a health care provider.

Some examples of such conditions include: advanced or rapidly growing cancers, acute life-threatening illnesses, chronic life-threatening conditions in need of immediate care, life-threatening infections, severe injuries arising from automobile or other serious accidents, and severe or life-threatening conditions involving failure of bodily organs or intermittent, as in periodic absences for chemotherapy or other procedures.

Membership

- To be eligible for membership to the Medical Leave Assistance Program, an employee must hold a "benefit eligible" position and accrue paid sick and/or annual leave.
- Employees making the required sick and/or annual leave donation to the Bank become "members."
- Only members may apply for leave grants from the Medical Leave Assistance Program.

Enrollment

- At least forty-five (45) initial members are required to implement this program.
- Membership to the Medical Leave Assistance Program will be offered twice a year during the months of October and May.
- Only program members can donate and apply for leave from the Medical Leave Assistance Program.
- To become a program member, an employee must contribute a minimum of two (2) days or sixteen (16) hours of sick and/or annual leave.
- Members must retain at least one-hundred and sixty (160) hours of combined sick and annual leave after any donation.

Required Donation from Members

- All donated leave must be given voluntarily.

- Members will initially donate two (2) days or sixteen (16) hours of sick and/or annual leave by completing a Medical Leave Assistance Program Membership Form.
- An additional contribution of eight (8) hours per calendar year to be taken out annually on December 31 is the minimum amount required to continue being a member of the leave grant pool. If a plan member has been receiving donated leave in the present calendar year and does not have the required renewal amount (8 hours in December) to continue membership in the plan, the required annual donation will be waived. All FML regulations still apply.
- A member may contribute up to a maximum of one-hundred (100) hours of sick and/or annual leave during each calendar year.
- Donated leave will be deducted from the member's accumulated leave accrual and transferred to the Medical Leave Assistance Program Bank by Human Resources.
- Mid-year assessments of up to two additional days may be transferred from member's sick and/or annual leave accrual if the Bank reserve falls below 40 total days or 320 hours. Members will be notified if such deductions are necessary.
- The automatic charge to replenish the pool may occur only one time per calendar year. Should the pool be depleted a second time in a given calendar year, no further request for Sick Leave will be accepted.
- Leave requests will be honored in the order in which they were placed when the pool is replenished, unless it is a person-to-person donation.
- Leave donations to the Bank are non-refundable and non-transferable.
- A member may withdraw from Bank participation during the months of October and May. Membership withdrawal shall result in forfeiture of all hours previously contributed.

Person-to-Person Donation

- Any participating plan member may donate **additional hours** (above the amount required to be a member in good standing) directly to another plan member employee who is requesting Medical Leave Assistance and has completed the application process. The same conditions and qualifications must be met and approved by the Medical Leave Assistance Program Committee.
- The Health Insurance Portability and Accountability Act requires personal health information to remain confidential. If a leave recipient makes it known to other employees that he/she is in need of leave, the requestor should alert the Committee of such. The person-to-person donation process would supersede the request of Bank hours. If the requestor does not receive sufficient hours from the person-to-person process, remaining hours may be granted from the Bank.
- The same restrictions, minimum balances, application process, etc., apply when an employee donates directly to an identified employee in need of leave.

Voluntary Donation from Terminating Employees

- Upon termination of employment from Georgia Southern University, a member may contribute a maximum of 80 hours from their unused sick leave to the Medical Leave Assistance Program Bank. This donation can be done anytime throughout the year and not only during the months of May and November. However, donation must be made prior to the employee's last day of employment.

Routine Childbirth

- A member with less than 4 weeks of accumulated sick and annual leave accrued at the time of birth may request up to fifteen (15) days of paid leave immediately following the birth of the child. Accumulated sick and annual leave must be used first before shared leave will be authorized. An employee may request leave before exhausting all of their own personal leave.

Procedure for requesting leave

- Members must complete the required Medical Leave Assistance Program application form.
- The member's medical care provider must complete the Medical Leave Assistance Program Physician's Confirmation of Qualifying Medical /Mental Health Condition form (form located at the end of the policy) and return the form to the Medical Leave Assistance Program Committee.
- In the event a member is physically or mentally unable to make a request to the Medical Leave Assistance Program Committee for use of the Leave Bank, a family member or agent may file the request.
- The Medical Leave Assistance Program Committee will review all applications within ten (10) days of receipt.
- Donors and recipients must complete all required forms.
- Department heads may be asked for input before the Medical Leave Assistance Program Committee makes their decision.
- The Medical Leave Assistance Program Committee will consider the member's overall attendance and job performance records, if applicable.
- A donor may designate the recipient of their donated days. See person-to-person donation section above.
- Leave taken under this policy must qualify under the Family and Medical Leave Act and must be taken concurrently with leave under FMLA. Please see Policy Number 2355 for guidelines on the the Family Medical Leave.

Recipient Benefits

- Employees granted Medical Leave Assistance from the Leave Bank reserve will continue to accrue sick and annual leave if applicable.
- Recipients will be paid at their current rate of pay while on Medical Leave Assistance.

Repayment

- Members utilizing sick leave hours from the Medical Leave Assistance bank will not have to replace these hours, except as a regular contributing member to the bank.

Restrictions

- A member may not receive Medical Leave Assistance until they have exhausted all personal accumulated sick and annual leave, and any applicable compensatory time.

- Medical Leave Assistance granted from the Bank shall not be for more than twenty (20) consecutive workdays or 160 work hours for which the applicant would have otherwise lost pay.
- A member may submit a request for an extension of his/her leave grant before or after their prior grant expires.
- Sixty (60) days is the maximum number of days any member may receive in any twelve (12) month period.
- The maximum number of leave days any participant may receive during the life of their employment is 180 days.
- Leave may be granted only for absences that will occur in the future, not for absences that occurred prior to the review of the Medical Leave Assistance Program Committee.
- If the Leave Bank falls below 320 hours, the recipient will be granted no more than 20% of the available hours. Exceptions will be made for person-to-person requests.
- If no days are available in the Leave Bank, grants will not be awarded.

Exclusions

- Employees who become eligible for other paid benefits will be considered ineligible for Medical Leave Assistance Program. For example, but not limited to: Workers' Compensation, short or long term disability, disability retirement benefits.

Medical Leave Assistance Committee

- A five-member Medical Leave Assistance Program Committee will be appointed by the President and chaired by the Leave Administrator in Human Resources.
- The committee will be comprised of the following:
 - Staff Council Representative
 - Faculty Senate Representative
 - Three (3) at-large members
- Each member will serve on the committee for at least three (3) years for continuity and historical reasons.
- The committee will monitor the program; make policy recommendations; review and rule on employee applications for Medical Leave Assistance Program grants.
- Committee members shall take action within ten (10) days of receiving a request.
- Committee members will consider medical documentation, the employee's attendance and performance record.
- A quorum of three members is required to meet and act upon a request for medical leave assistance.
- All forms and records pertaining to the Medical Leave Assistance Program and actions by the Committee will be maintained in confidential files in the Human Resources Department.
- The decision of the Committee is final and not grievable.

- The Committee will follow all HIPAA laws and regulations.
- The identity of donors and recipients will be kept confidential, except as required to administer the policy and for any required legal action.
- When a recipient returns to work, the medical condition ends, or employment terminates, Medical Leave Assistance leave remaining in the recipient's balance will be restored to the Medical Leave Assistance Leave Bank.
- When a member's employment is terminated, Bank leave will not be included in any lump-sum payment for payout.

Loss of Benefits

- A member will lose their right to plan benefits if they:
 - ✓ Resign or terminate employment
 - ✓ Cancel plan membership
 - ✓ Are on an approved leave of absence in a non-pay status for reasons other than illness, injury or disability
 - ✓ Engage in activities or work deemed to be inconsistent with their medical certification while receiving Medical Leave Assistance
 - ✓ Misrepresent their medical condition or disability
 - ✓ Retire
 - ✓ Fail to make an annual contribution.

Forms (see below):

Medical Leave Assistance Program Donor & Recipient Form

Medical Leave Assistance Program Membership Form

Medical Leave Assistance Program Physician's Confirmation Form

Georgia Southern University

Medical Leave Assistance Program Membership Form

Name of Donor (Print): _____

Employee ADP ID #: _____ FTE (1.0, .75, .50) _____ Faculty _____ or Staff _____
(Full Time Equivalency)

Department and P.O. Box #: _____

Email Address: _____

Telephone #: _____

I wish to become a member of the Medical Leave Assistance Program.

In doing so,

- I understand that I must be in a benefitted position at Georgia Southern University that accrues sick and/or annual leave.
- I must initially, voluntarily contribute as a one-time membership a minimum of two (2) days or sixteen (16) hours of sick and/or annual leave.
- **Donation: Sick Leave Hours _____ and/or Annual Leave Hours _____**
- In order to remain an active participating member, I must voluntarily contribute an additional eight (8) hours of sick and/or annual leave per calendar year to be taken out every participating year on December 31.
- I must retain at least one-hundred and sixty (160) hours of combined sick and annual leave (if applicable) after any required donation.
- I understand and agree that the University may request of me to donate a maximum of two (2) additional days or sixteen (16) hours to the Leave Bank if at the mid-year assessment, the Bank reserve falls below 320 hours. This request may only be done once a year.
- I understand and agree that leave donations to the Bank are non-refundable, non-transferable and **cannot be withdrawn**.
- I will abide by the Medical Leave Assistance Program policy.

Signature of Donor Member: _____ Date: _____

For Use By the Georgia Southern University's Human Resources Leave Administrator.

Transfer Approved: _____ Transfer Not Approved _____

This is to advise you that your request to join Georgia Southern University's Medical Leave Assistance Program cannot be accepted due to the following reason(s): _____

Signature of Leave Administrator: _____ Date: _____

Georgia Southern University
Medical Leave Assistance Program
Physician's Confirmation of Qualifying Medical / Mental Health Condition

Part A: To be completed by the Employee or Person acting on behalf of the Employee

Employee Name: _____ **Dept:** _____ **Telephone #:** _____

I understand that the information requested on this Physician's Certification is for the use of determining my eligibility to participate in the Medical Leave Assistance Program at Georgia Southern University. Failure to provide all the requested information will result in my request not being processed or approved by the Medical Leave Assistance Program Committee. Further, I am aware that any medical information provided will remain confidential and will not be shared with other employees in Human Resources, my Department or elsewhere within the University. If I am acting on behalf of the employee patient, I am providing documentation as having Power of Attorney with this form.

Employee Patient Signature: _____ **Date:** _____

Print name of person acting on behalf of the Employee Patient: _____

Signature of person acting on behalf of the Employee Patient: _____

Contact Telephone Number: _____

Part B: To be completed by the Physician

Definition: *Life-threatening or emergency medical / mental health condition* means a health condition involving a serious, extreme, or life-threatening illness, impairment, or condition that is likely to require an employee's absence from duty for a period of time longer than the amount of sick and annual leave available to the employee, and the health condition is such that it is not medically appropriate for the employee to delay the absence in order to accrue additional sick or annual leave prior to the absence. The medical condition requires on-going treatment and supervision by a health care provider.

Some examples of such conditions include: pregnancy, advanced or rapidly growing cancers, acute life-threatening illnesses, chronic life-threatening conditions in need of immediate care, life-threatening

infections, severe injuries arising from automobile or other serious accidents, and severe or life-threatening conditions involving failure of bodily organs or intermittent, as in periodic absences for chemotherapy or other procedures.

1. In your opinion, does the employee meet the "life-threatening or emergency medical / mental health condition" definition as described above? Yes ___ No ___. If "no", sign and date this form of page 2. If "yes", please complete the next question

2. **Diagnosis & Prognosis** (anticipated length of time the patient will be unable to work full-time):

3. **Estimated date of onset of medical condition:** _____ or
due date of birth of child _____.

4. **When could the patient resume work?** _____ Any
restrictions? Yes ___ No ___. If yes, please be specific:

I certify the following: (please check all that are applicable)

_____ I am the attending physician for this patient.

_____ This patient suffers from a medical condition that requires on-going treatment
and supervision by a physician including pregnancy/childbirth.

_____ The patient's inability to return to work was not due to elective surgery.

Name of attending Physician: _____
Please Print

Attending Physician's Signature: _____ Date: _____

Telephone Number: _____

Please return the completed form directly to the employee, or to Georgia Southern University's Department of Human Resources, Benefits Office, P.O. Box 8104, Statesboro, GA 30460. You may also fax the information to our Benefits Office at 912-478-0325.

Georgia Southern University
Medical Leave Assistance Program
Donor & Recipient Application

Part I - Donor

Employee Name: _____ ADP ID#: _____

Department: _____ Office Phone: _____ or Home Phone: _____

A – Donor Request

Approval is requested to donate additional hours, above and beyond the required membership hours:

_____ hours of sick leave and/or _____ hours of annual leave to:

_____ Leave Bank and/or _____ person-to-person _____
Recipient's Employee Name

By signing this section, I hereby certify that this request is being made voluntarily. I was not coerced, threatened, intimidated, or financially induced to donate leave for purposes of the medical leave assistance program. Furthermore, I understand my donation of leave time through the medical leave assistance program is not tax deductible as a charitable contribution.

Signature of Donating Employee: _____ Date: _____

B – Eligibility Verification

Donor's Leave Balance: _____ Hrs. Sick _____ Hrs. Annual as of _____ (date)

Part II – To be completed by Applicant for Medical Leave Assistance

Employee Name: _____ ADP ID#: _____ FTE (1.0, .75, .50) _____
(Full Time Equivalency)

Department: _____ Office Phone: _____ or Home Phone: _____

I request to receive medical leave assistance hours in accordance with Georgia Southern University's Medical Leave Assistance Program. I certify that my extended absences are the result of a personal medical /mental condition that qualifies under the Medical Leave Assistance Program, and that this condition has caused, or is likely

to exhaust all paid leave and place me on "leave without pay" status. **I have enclosed the completed form entitled Physician's Confirmation of Qualifying Medical / Mental Health Condition.**

I have not directly or indirectly solicited donations of sick or annual leave time from other Georgia Southern University's employees independently. I have not interfered with any right which another employee may have with respect to contributing as described in the Georgia Southern University's Medical Leave Assistance Program. I certify that the above statements are true and complete to the best of my knowledge. If I am acting on behalf of the employee recipient, I am providing documentation as having Power of Attorney with this form.

Signature of Applicant or Authorized Recipient Representative: _____ Date:

_____ Authorized Recipient Representative Phone #: _____

Instructions: Please forward this form and supporting documentation to the Human Resources Benefits Office, % of Leave Administrator, PO Box 8104, Statesboro, GA 30460. **Please mark "Confidential."**

Part III – To be completed by Human Resources Leave Administrator

A – Eligibility Verification:

Employee's leave balance: _____ Hrs. Sick _____ Hrs. Annual as of _____ (date)

This employee is a current member of the Medical Leave Assistance Program. ___ Yes ___ No

B – Recommendation of Unit Administrator(s):

Recommend approval for leave _____ Do not recommend approval for leave _____.

Unit Administrator Signature Date

Comments:

C – Medical Statement – The Physician's Confirmation of Qualifying Medical / Mental Health Condition has been received and verifies that the applicant's condition qualifies for Medical Leave Assistance Leave under the provision of the program. ___ Yes ___ No

D – Decision of the Medical Leave Assistance Program Committee

Approved _____ Number of Hours Granted _____ Disapproved _____

Chair Signature: _____ Date of Committee Action: _____