THE UNIVERSITY OF ARIZONA
HUMAN RESOURCES

COMPASSIONATE TRANSFER OF LEAVE REQUEST FORM

INFORMATION ABOUT REQUESTING EMPLOYEE

(Form may be completed by the requesting employee's personal representative or department if the employee is incapacitated.) Submit the completed and signed form to the department representative.

1) Name: _____ _____ _____
Last First Middle

2) EID: _____ **3) Employment Category (check one):** Classified Staff ☐ Appointed Personnel ☐

4) Leave Start Date: _____ **5) Expected Return to Work Date (if known):** _____

6) Maximum number of Compassionate Transfer of Leave hours requested (if known): _____

I request that I be allowed to receive any compassionate transfer of leave contributions designated for me. According to the Compassionate Transfer of Leave Policy, I understand that I must meet the following criteria. Initial on *each* line.

____1. I have passed my initial probation period.

____2. I was eligible to accrue vacation hours at the time my leave began.

____3. I have exhausted all forms of paid leave (vacation, sick leave, and compensatory time) prior to the leave transfer.

____4. I am not eligible to receive long term disability benefits or workers compensation benefits. If I become eligible to receive such benefits, I will no longer be eligible to receive compassionate transfer of leave.

____5. I understand that compassionate transfer of leave contributions may be used to supplement short term disability payments up to, but not to exceed, my regular rate of pay.

____6. My contributions can not exceed the anticipated period of disability. In the event that I should return to work early, I understand that I will be responsible for any overpayment of contributions received.

____7. I have attached a doctor's statement that confirms that I am unable to perform all duties of my job or any available light duty work, and the anticipated duration of my disability is at least 45 calendar days from my last day of work.

_____ _____
Employee Signature Date

PROCESSING INFORMATION (To be filled out by requesting employee's department representative)

Was this an on-the-job injury? No ☐ Yes ☐ (contact Risk Management to prevent subsidization of worker's comp benefits)
Employee's Pay Rate Per Hour: _____

To the best of my knowledge, this employee has met eligibilityrequirements to receive contributions under the Compassionate Transfer of Leave Policy.* Submit completed form to Human Resources (University Services Building, Room 114).

_____ _____
Department Representative Date

FOR HUMAN RESOURCES USE ONLY

Date employee will exhaust own accruals (vacation, sick, and compensatory time).

Month/Day/Year: _____ Hours on this date: _____

Sick hours to be added to employee's balance by Payroll: _____ x $ _____ = $_____
Sick Hours Credited | Hourly Rate | Dollar Value

For FSO Use Only	Sick	10	21 24	26 HOURS 32	33
		HA	5102	| | | | ^ |	+

Projected date contributions will be exhausted including new vacation and sick accruals as well as any holidays (not to exceed return to work date). Month/Day/Year: _____ Hours to this date: _____

*Referenced Policies:
Arizona Board of Regents Policy #6-809
Classified Staff Personnel Policy and Procedure #201.1
University Handbook for Appointed Personal Policy and Procedure #8.02.04