

COMPASSIONATE TRANSFER OF LEAVE REQUEST FORM

Was this an on-the-job injury? No \(\subseteq \text{Yes} \subseteq (contact Risk Management to prevent subsidization of worker's comp benefit	HUMAN RESOURCES						
Incapacitated.) Submit the completed and signed form to the department representative.	INFORMATION ABOUT REQ	UESTING EMPLOY	/EE				
Last First Middle 2) EmpID: 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): 1						e employee is	
Last First Middle 2) EmpIID:		·					
4) Leave Start Date:	Last		Fir	st		Middle	
I request that I be allowed to receive any 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 PROCESSING INFORMATION (To be filled out by requesting employee's department representative) Was this an on-the-job injury? No \(\subseteq \text{ Yes} \) (contact Risk Management to prevent subsidization of worker's comp benefit Employee's Pay Rate Per Hour: 7. To the best of my knowledge, this employee has met eligibility requirements to receive contributions under the Compassiona Transfer of Leave Policy.* Submit completed form to Human Resources (University Services Building, Room 114). Department Representative Date FOR HUMAN RESOURCES USE ONLY Bate employee will exhaust own accruals (2) EmplID:	3) Employment C	Category (check one): Classi	ified Staff	Appointed F	'ersonnel [
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Arizona Board of Regents Policy #6-809

Classified Staff Personnel Policy and Procedure #201.1

exceed return to work date). Month/Day/Year: _

University Handbook for Appointed Personal Policy and Procedure #8.02.04

Hours to this date:

^{*}Referenced Policies: