Recipient Affidavit
Donated Sick Leave Request Form

I request to utilize hours from the Donated Sick Leave Program under the terms specified in the Georgia Tech Donated Sick Leave Program description and with the understanding that the specific nature of my/my spouse's/parent's/my child's illness will be kept in confidence.

Name of Recipient ____________________________ **Employee ID** ______________________

Department Code _____________________________ **Mail Code** ________________________

Email _______________________________________ **Phone** ___________________________

Date Qualifying Condition Began ________________________ **Date Qualifying Condition Ended or Is Expected to End** ____________________

Number of Donated Sick Leave Hours Requested _____________ **Date to Begin Use of Donated Sick Leave Hours** _____________

I am submitting herewith medical verification (Physician's Certification Form) which confirms a serious medical condition as described in the Georgia Tech Donated Sick Leave Program policy.

I certify that the above information is true and complete to the best of my knowledge.

____ ________________
Signature of Recipient or Authorized Recipient Representative **Date**

____
Printed Name of Authorized Recipient Representative

____ ________________
Signature of Supervisor **Date**

____ ________________
Printed Name of Supervisor, Department and Title **Date**

INSTRUCTIONS: Please return this form to:

Director, Benefits
Office of Human Resources
Georgia Institute of Technology
500 Tech Parkway
Atlanta, GA 30332

Mark as private and confidential.

Physician's Certification Form

Part A. To Be Completed by the Employee

Employee Name	Employee ID	FTE (1.0, .75, .50)	Phone

Department/Mail Code	Street Address, City, State, Zip Code

Part B. To Be Completed by the Physician

Definition: Serious medical condition means a health condition involving a serious illness, injury, impairment, or condition that is likely to require the employee's absence from work for an extended 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. Some examples of such conditions include: advanced or rapidly growing cancers, acute serious illnesses, chronic life-threatening conditions involving failure of bodily organs or systems (e.g., heart attack) or chronic conditions requiring extended rehabilitation such as back surgery. The absence may be continuous, as in hospitalization following surgery or an accident, or intermittent, as in periodic absences for chemotherapy or other procedures.

(Attach additional sheet if more space is needed).

In your opinion, does the employee (or spouse, parent or child) meet the "serious medical condition" definition as described above?

Check One: YES ☐ NO ☐

Date patient was first unable to work ______________________________

Diagnosis description ______________________________

Has the patient been hospital confined?

Check One: YES ☐ NO ☐

If yes, provide hospital name and admittance date ______________________________

Prognosis (possible duration of condition) ______________________________

When could patient resume work? (List any restrictions to regular duty). ______________________________

Physician's Certification Form – page 2

Physician's Name:

____________________________ ____
(Please Print) **Specialization**

____
Street Address, City, State, Zip Code

____ __________________
Physician's Signature (please do not use stamp) **Date**

Part C. To Be Completed by the Employee or Person Acting on Behalf of the Employee

I understand that the information requested on this Physician's Certification of Emergency or Life Threatening Medical Condition Form is for the use of determining my eligibility to participate in the Donated Sick Leave Program at the Georgia Institute of Technology. Failure to provide all the requested information will result in my request not being processed or approved by the Donated Sick Leave Certification Committee. Further, I am aware that any medical information provided will remain in confidence.

____ __________________
Employee Patient Signature **Date**

____ __________________
Printed Name of Person Acting on Behalf of Employee Patient **Date**

____ __________________
Signature of Person Acting on Behalf of Employee Patient **Date**

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