MONTCLAIR STATE UNIVERSITY

DONATED LEAVE PROGRAM

Recipient Affidavit Form

Applicant must sign and submit Recipient Affidavit to participate in Donated Leave Program. Applicant must receive at least five sick days or vacation days or a combination thereof from one or more leave donors to participate in the donated leave program. Applicant shall receive no more than 260 sick days for a lifetime.

1. I have read the procedure regarding the Donated Leave Program and I consent to participation in this program.

2. I understand that participation in the Donated Leave Program will result in the posting to department employees regarding my eligibility. (The specific nature of illness will be kept confidential).

3. I certify that I have not offered anything of value to any employee in exchange for the donation of paid Leave time to me.

4. I have not directly or indirectly intimidated, threatened or coerced any employee for the purpose of obtaining a donation of paid leave.

5. I have not interfered with any right which another employee may have with respect to contributing, receiving or using paid leave under this program.

6. I understand that I cannot receive temporary disability (TDI) benefits for the same periods that I am paid wages from donated sick and/or vacation leave or while using any of my own paid leave time.

7. I also understand that the Temporary Disability Benefits Law requires that I use all of the donated leave before benefits can be paid.

8. I have submitted medical certification which confirms a serious health condition or injury to the office of Employee Benefits.

_____ _____ _____

DATE **PRINT NAME** **SIGNATURE**

RETURN AFFIDAVIT TO: ***OFFICE OF EMPLOYEE BENEFITS***

Email: hr-benefits@montclair.edu ***Fax: 973-655-351***

HR USE ONLY

_____ Transfer Approved _____ Transfer Denied

_____ Sick balance (hrs) _____ Vacation Balance (hrs)

Request to receive donate leave time cannot be processed due to the following reason(s):

___ Recipient/Donor is longer active

___ Employee/Recipient does not meet eligibility requirements

___ Employee/Recipient has already received the maximum number of donated days

___ No medical certification on file

_____ _____

Authorized Signature Date