



Capital School District

RDL - REQUEST FOR DONATED LEAVE FORM

Section: Human Resources

Title: RDL - Request for Donated Leave

Effective Date: July 1, 2025

Revision Date: May 15, 2025

Part I: Employee Information – Completed by Employee or Designee

Employee Name (Last, First, MI): _____

Employee ID: _____ Date of Birth: _____

Mailing Address (Street, City, State, Zip): _____

School/Building: _____

Date of Hire: _____ Telephone Number: _____

Illness¹ of (check one) ☐ Employee ☐ Family Member

Family Member's Name: _____ Relationship to Employee: _____

Family Member's Address (Street, City, State Zip): _____

The following questions must be answered for employee or impacted family member.

Date of Accident/Illness: _____

Date Disability Began: _____ Expected Returned to Work Date: _____

Nature of Illness/Injury (Brief Description – no diagnosis due to GINA and ADA): _____

Date Treatment Began: _____ Name of Treating Physician: _____

Physician's Telephone Number: _____

Physician's Address (Street, City, State Zip): _____

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, medical institution, pharmacy, governmental agency, or my present employer having information concerning me, to release said information to the State of Delaware or its designated representative to be used for determination of my eligibility for Donated Leave.

This authorization shall be valid from the date signed through the duration of this claim. In order to be eligible to receive Donated Leave beyond 30 days, I will resubmit a certification from my treating physician certifying continued disability/illness.

Name, Address, & Phone Number of Individual Completing RDL (If applying on behalf of Employee):

I request that I be allowed to receive donated leave under the Capital School District Donated Leave Program. I certify that (1) I have been a State Officer or employee for at least 6 months prior to the request; (2) I have used all of my sick leave and one-half of my annual leave; however, for the illness of a family member, I certify that I have used all of my sick and annual leave; (3) I have established medical justification for such receipt, which must be renewed every 30 days.

To qualify for the Donated Leave program, I must provide my Agency Human Resources Office with a physician's statement detailing the start date of my catastrophic illness or injury, a description of the condition, a recovery prognosis, and the estimated date of my return to work.

☐ I certify that the above statements are true.

Employee Signature or Individual Applying on Behalf of Employee

Date

☐ By using this form, the parties acknowledge their agreement to conduct transactions by electronic means. A party's electronic signature for purpose of the Uniform Electronic Transactions Act, 6 Del. C. Ch. 12A may be provided by checking a box as indicated, electronic initials or name, or email confirmation.

¹ *Illness is defined as any illness or injury to the employee or to a member of an employee's family which is diagnosed by a physician and certified by the physician as rendering the employee or the member of the employee's family unable to work; or in the case of family member who does not work, the equivalent of "unable to work" for a period greater than 5 calendar weeks or the equivalent in separate 7 calendar days or full calendar week periods resulting from the same or related medical condition and occurring within the same 12 consecutive month period.*

Part II: Completed by HR Representative

Date Employee Employed by the State for 6 months: _____

Employee's last date worked: _____

Date all Sick Leave will be/was Exhausted: _____

Date One-Half Annual Leave, or all annual leave if the request is for a family member, will be/was Exhausted: _____

Date all Annual Leave will be/was Exhausted: _____

FMLA Approval Dates: _____ Date Disability Began: _____

Short Term Disability Approval Dates: _____

HR Representative Signature: _____ Date: _____

Part III: Completed by HR Director

- ☐ The donated leave request has been reviewed by HR and it has been determined this employee meets all the criteria for the Donated Leave program.

I am authorizing the transfer of _____ donated leave hours to the employee listed on page one of this application.

HR Director Signature: _____ Date: _____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY - CONFIDENTIAL

Patient Name: _____ Patient DOB: _____

Notification to Healthcare Provider

Title II of the Genetic Information Nondiscrimination Act (GINA) "prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you do NOT provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic test, the fact that an individual or an individual's family member sought or receive genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Patient was/is ☐ Under my Professional Care From: _____ To: _____
☐ Hospitalized From: _____ To: _____

Dates of Treatment: _____

Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

Date Symptoms or Disability Began: _____

Is Condition Due to Serious Illness or Injury Arising out of Patient's Employment: _____

Period of Incapacity: From: _____ To: _____

During this time, will or did the patient need care? ☐ Yes ☐ No

If yes, explain the care needed by the patient and why such care is/was medically necessary.

EMPLOYEE LIMITATIONS/RESTRICTIONS *(skip if patient is a family member of the employee)*

Patient was or may be able to resume full duty employment, with no restrictions in work activities, on:_____.

If unable to presently return to full duty employment, can the patient return to less than full duty?
☐ Yes ☐ No

If yes, what is the period of partial incapacity? From:_____To: _____

Describe in detail any limitations or restrictions on the ability of the employee to work. List any assistive devices or equipment, or any accommodation the employee requires to perform his/her job.

☐ I hereby certify that the above information is, to the best of my knowledge and understanding, correct and true as of the date of the signature below.

Physician’s Signature:_____Date: _____

Printed Name:_____Phone Number: _____

☐ By using this form, the parties acknowledge their agreement to conduct transactions by electronic means. A party’s electronic signature for purpose of the Uniform Electronic Transactions Act, 6 Del. C. Ch. 12A may be provided by checking a box as indicated, electronic initials or name, or email confirmation.

***A copy of this completed Agreement must be sent to the Capital School District Human Resources Office.**