



# Stony Brook Medicine

## LEAVE DONATION PROGRAM PROFESSIONAL EMPLOYEE RECIPIENT APPLICATION

Please fax form to Human Resources 631-759-9203 or email to  
SBUHHR@stonybrookmedicine.edu

Employee Name: \_\_\_\_\_

Department: \_\_\_\_\_

Job Title: \_\_\_\_\_ Employee ID# \_\_\_\_\_

I wish to participate in the Leave Donation Program. I am absent due to a non-occupational personal illness or disability for which medical documentation was and will be provided on a monthly basis. I have exhausted all leave benefits as provided in Sections 23.2, 23.4 and 23.5 of the 2022- 2026 Agreement between the State and UUP. I expect to be absent for at least **one** biweekly payroll period following the exhaustion of such leave benefits. I have not had any disciplinary actions or unsatisfactory performance evaluations within the last three years of State employment.

I understand that while I am using donated leave credits I will be considered to be in leave without pay status for attendance and leave purposes. Therefore, I will not earn leave accruals or observed holidays.

- \_\_\_\_\_ I wish to use donated credits in full day units prior to attaining eligibility to receive benefits under the University’s Disability Insurance Program.
- \_\_\_\_\_ I wish to use donated credits in half day units prior to attaining eligibility to receive benefits under the University’s Disability Insurance Program.
- \_\_\_\_\_ Donated credits must be used in full day units after attaining eligibility, but prior to the receipt of benefits under the University’s Disability Insurance Program. Donated credits can no longer be used once an eligible employee begins receiving disability benefits.

I agree to allow my name to be shared with Union Representatives and co-workers for purpose of obtaining leave donations on my behalf: \_\_\_\_\_ (employee initials).

\_\_\_\_\_  
Recipient Signature

\_\_\_\_\_  
Date

\*D165\*