Kiel Voluntary Vacation/PTO Donation Program
APPLICATION Form

PLEASE TYPE OR PRINT INFORMATION

APPLICANT INFORMATION

DUKE UNIQUE ID #:	☐ **Nonexempt (Biweekly)** ☐ **Exempt (Monthly)**	E-Mail Address:	
Last Name:	First Name:		M.I.:
Home Address:		Home Phone :	
City:	State:	Zip :	
Dept/Org Unit Name: ____________________ Continuous Service Date: ________________		Work Schedule: Hrs/Wk _______ Wks/Yr _______	
Purpose of Leave:		Estimated Length of Absence:	

I understand that:

- *It is my responsibility to read the provisions of the Kiel Voluntary Vacation/PTO Donation Program including frequently asked questions.*
- *The completed application must be submitted to the Benefits office before or during my absence.*
- *Recipients are only eligible to use donated hours after the end of their 4 week absence and after their paid time off has been exhausted.*
- *I certify that if the purpose of this leave is to care for my dependent that the dependent meets the Internal Revenue Service definition of a dependent.*

Recipient's Signature: ____ Date: ____________________

APPLICANT SUPERVISOR INFORMATION

Supervisor's Last Name:	Supervisor's First Name:	
Dept/Org Unit Name: ___________ Org Key: *(Pay Point – 4 Characters)* ______________		Work Phone:
Supervisor's E-Mail Address:		

Has this applicant exhausted all of their paid time off? ☐ Yes, then when? ☐ No, then when?

If the applicant has stopped working, then please provide last day worked:

When will the applicant return to work?

I understand the policies of the Kiel Voluntary Vacation/PTO Donation Program and certify that this applicant has no active disciplinary action on file, and that the applicant also meets the other requirements of the Kiel Program.
It is my responsibility to notify Benefits when the applicant/employee returns to work.

Supervisor's Signature: Date:

Payroll Representative Name:	Payroll Rep. Work Phone :

Payroll Representative E-Mail Address:

COMPLETED FORM with medical documentation are to be sent to: Benefits, PO Box 90502, 705 Broad St., Durham, NC 27705 or faxed to 681-8774. Benefits will send an e-mail about claim status to the applicant within three business days.

THE ATTACHED MEDICAL DOCUMENTATION MUST BE COMPLETED BY YOUR PHYSICIAN AND ATTACHED TO THIS APPLICATION

Revised March 30, 2007

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Kiel Program Policy Summary

In order to be eligible to receive a donation from the Kiel Memorial Voluntary Vacation/PTO Donation Program, an applicant must meet all of the eligibility requirements listed below:

- Regular employee of Duke University or the Duke University Health System.
- Have a work schedule of at least 20 hours per week.
- Employed by Duke for at least 90 consecutive days.
- No corrective action warnings or suspensions within the last 12 months.

Note: Recipients are only eligible to use donated hours after the end of their 4 week absence and after their paid time off has been exhausted.

Donations:

- Vacation or Short Term Bank PTO donations will not be transferred from the donor to the recipient until all of the recipient's existing vacation/PTO hours have been exhausted.
- The donation is paid per normal payroll schedule up to a maximum of 13 weeks (520) hours within a twelve-month period. Manual checks will not be cut.
- The need for a donation must be due to a catastrophic medical event, which requires the employee to be out of work for at **least 4 weeks** (medical documentation must be attached to application).
- Certification of a qualifying medical condition is required from an eligible health care provider. Conditions that are certified for periods less than 13 weeks (520 hours) are eligible to receive time from the Vacation or PTO STB donation limited to that time certified by the health care provider. If the entire 13 weeks (520 hours) are not used, eligibility may be renewed within the designated 12-month period not to exceed 13 total weeks (520 hours).
- During an employee's first year of employment, donations must be specified for that employee.
- All applications for leaves, as well as medical information, are confidential and are not included as part of the employee's personnel file. Donors shall remain anonymous unless the donor provides written consent authorizing the release of information.

Payment of Vacation or Paid Time Off (STB) Donation and Impact on Benefits:

- Recipients are only eligible to use donated hours after the end of their 4 week absence and after their paid time off has been exhausted. Once approved, there can be up to a three-week period before donations are reflected in the recipient's vacation or Paid Time Off bank (please review the Kiel web site for more specific information).
- The donated hours are paid at the recipient's regular rate of pay and from the recipient's account code(s).
- Staff receiving other payments such as workers' compensation, short-term disability, or long-term disability provided through Duke's insurance programs are not eligible to receive donations.
- If the staff member receives at least the equivalent of 30 voluntary donation hours per week, the employer contribution will continue toward the cost of benefit programs provided the staff member continues their portion of premium where applicable.

Certification of Health Care Provider (Family and Medical Leave Act of 1993)	U. S. Department of Labor Employment Standards Administration Wage and Hour Division
	OMB No: 1215-0181 Expires: 08-31-2007
1. Employee's Name	2. Patient's Name (if different from employee)

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

(1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____ , or None of the above ___

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5.a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity [2] if different):

5.b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in item 6 below)? _________

If yes, give the probable duration:

5.c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]:

6.a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated treatment if known, and period required for recovery if any:

6.b. If any of these treatments will be provided by another provider of health services (e.g. physical therapist), please state the nature of the treatments:

1. Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

2. "Incapacity", for purposes of the FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

6.c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g. prescription drugs, physical therapy requiring special equipment):

7.a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

7.b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? _______ If yes, please list the essential functions the employee is unable to perform

7.c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? __________

8.a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? ___________

8.b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? __________________

8.c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_________________________ (Signature of Health Care Provider)

_________________________ (Type of Practice)

_________________________ (Address)

_________________________ (Telephone Number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than full schedule:

____________________________________ __________________________
(Employee Signature) (Date)

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

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1. Hospital Care

Inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

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2. Absence Plus Treatment

A period of incapacity[2] of more than three calendar days (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

(1) Treatment[3] two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[4] under the supervision of the health care provider.

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3. Pregnancy

Any period of incapacity due to pregnancy, or prenatal care.

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4. Chronic Conditions Requiring Treatments

A chronic condition which:

(1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition): and

(3) May cause episodic rather than a continuing period of incapacity[2] (e.g. asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity[2] which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

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3. Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

4. A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity[2] of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertifications. (29 CFR 825.306)

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

Public Burden Statement

We estimate that it will take an average of 10 minutes to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, NW, Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

Revised March 30, 2007