DPS Leave Transfer Pool Recipient Request Form

COMPLETE AND FORWARD TO IMMEDIATE SUPERVISOR; SUPERVISOR WILL RECOMMEND APPROVAL OR DENIAL AND FORWARD TO THE OFFICE OF HUMAN RESOURCES VIA CHAIN OF COMMAND.

EMPLOYEE NAME: _____

PERSONNEL NUMBER: _____

DIVISION / AREA: _____

Provide a brief description of the nature, severity, and anticipated duration of the medical, family, or other hardship affecting the employee. Provide a physician's certification or other pertinent documentation to support the request. Sensitive medical information or other documentation which you wish to be kept confidential may be submitted separately and forwarded directly to the Office of Human Resources.

By signing below, I indicate my understanding that each separate leave pool transfer request must be limited to no more than THIRTY (30) working days. I understand that, if approved, I must use all applicable accrued leave balances before using transferred leave. I understand that when my personal emergency terminates, any remaining balance of transferred leave will be restored to the appropriate agency Leave Transfer Pool account.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

THIS REQUEST MUST BE APPROVED BY THE EMPLOYING AGENCY. THE DETERMINATIONS OF THE AGENCY ARE FINAL; THERE WILL BE NO ADMINSTRATIVE OR JUDICIAL APPEAL.

Supporting documentation may be attached as necessary to support your determination below.

CONCURRENCE ○ **NON-CONCURRENCE** ○

Supervisor's Signature _____ Date _____

○ ○

Deputy Director / Department Head's Signature _____ Date _____

ELIGIBLE ○ **INELIGIBLE** ○

OHR Leave Manager's Signature _____ Date _____

RECOMMENDED ○ **NOT RECOMMENDED** ○

OHR Administrator's Signature _____ Date _____