

**STATE OF ALABAMA  
PERSONNEL DEPARTMENT  
REQUEST FOR DONATED LEAVE**

**Instructions for Form 25**

**A doctor's statement giving the diagnosis and the specific nature of the situation must be attached to this form.**

There is a place at the top to check whether the form is being submitted as an initial request or a recertification. In either case, the original must be submitted to State Personnel. If the absence is for more than thirty days, a recertification Form 25 must be submitted, accompanied by a statement from the physician certifying that the employee is still incapacitated with the same illness/injury. These updates must be completed every thirty days in order for the employee to continue to receive donated leave.

To be completed by the employee or their advocate:

Employee Name – complete name as it appears in GHRS

SSAN – full Social Security Number must be given

Department – name (not number) of the employee's agency

Division – name or number designation of the employee's division if applicable

Class Code – the 5 digit class code (do not enter the title)

Pay Range – pay grade assigned to the class

**Additional Information:**

The employee or their advocate may enter pertinent information if they so desire. In caretaker instances, the name of the person to receive care and their relationship to the employee should be given in this space.

**Signature Block/Date:**

Beneficiary Employee: The beneficiary employee must sign unless they are physically unable to do so. If an advocate signs, they should sign their own name, their relationship to the employee, and the reason the employee is unable to sign. (i.e. in a coma) The date of the signature should be entered.

**Authorization/Date:**

Beneficiary Employee: The beneficiary employee must sign this waiver if they wish to be listed on the State Personnel website and other publications. If they do not, the line should remain blank.

**Beneficiary Appointing Authority/Date:**

The beneficiary appointing authority must sign and date the appropriate line giving departmental permission for this employee to receive donated leave, if approved.

**Approved Personnel Director/Date:** If approved, the form will be signed and dated. Leave cannot be granted before this date.

**Donated Leave Approved For:** The illness/injury for which donated leave has been approved will be printed here.

New       Recertification

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Employee Name		SSAN	
Department		Division	
Class Code		Pay Range	

Additional Information:

I do hereby request donated leave under Code of Alabama §36-26-35.2 (2001). This request is due to the catastrophic illness/injury referenced on the attached doctor's statement and is needed in order to continue my compensation because my leave will have been exhausted prior to my return to work. Under the FMLA, if a qualifying illness exists, an employee's job is protected for 12 weeks. I understand that the receipt and/or use of donated leave does not protect an employee's job after the 12 weeks covered by the FMLA are exhausted. I understand that I shall not coerce, reimburse, or provide any form of compensation to any person who donates leave to me or on my behalf.

Beneficiary Employee: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION**

I do hereby authorize the State Personnel Department to publish on its web site and in any of its other publications a general description of the illness/injury for which I have been granted donated leave. This authorization is for the purpose of notifying the state workforce of my request for donated leave and soliciting leave on my behalf.

Beneficiary Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Pursuant to the Code of Alabama §36-26-35.2 (2001), I request that our employee be approved for receipt of donated leave. A doctor's statement outlining the condition and treatment is attached. I authorize my agency to add the total hours donated after approval by State Personnel to the above beneficiary.

Beneficiary Appointing Authority: \_\_\_\_\_ Date: \_\_\_\_\_

Approved

Personnel Director: \_\_\_\_\_ Date: \_\_\_\_\_

Donated Leave Approved For: