

Leave Donation Request

Revised 1/3/22

Completed Form Must Be Submitted to the
Human Resources Department For Final Approval

Employee Name – PRINT Last Name, First Name	
Employee #	
Department	
Contact Phone #	
Home Mailing Address	

I have been off work for a serious health condition qualifying under Federal/Wisconsin Employee and Family Medical Leave (FMLA) due to:

- Own illness or injury and wish to receive leave donations for:
- Income Continuation Insurance elimination period
 - Full duration of your recovery period

- The illness or injury of his/her family member (relationship)

--

I anticipate being off work until (date)

--

Please send my request to:

- My department
 County-wide

I authorize the below “medical health information” may be shared. If nothing is provided, I understand that the County will only share that “I’m off work due to a FMLA qualifying medical condition.”

--

I authorize Marathon County to communicate in written and/or verbal formats the above listed medical health information that precipitated my request for participation in the leave donation program. I release Marathon County from all legal responsibilities that may arise from this action. I understand that departments or divisions of Marathon County may exchange information about my condition to enable the coordination of leave donations from my co-workers. I understand that the health information disclosed because of this authorization may no longer be protected by the federal privacy standards and my health information may be disclosed without obtaining my authorization.

I understand that donor’s name and hours donated will not be shared with me.

This authorization is good until the following date:

--

By signing this authorization, I am confirming that it accurately reflects my wishes.

Employee Signature – Typed Name	
Personal Representative Signature – Typed Name	
Date	

**Forward Completed Form To Human Resources Department
Countybenefits@marathoncounty.gov**