



VACATION DONATION PROGRAM RECIPIENT APPLICATION

APPLICANT INFORMATION AND AUTHORIZATION:

APPLICANT'S NAME (LAST, FIRST, M.I.)	EMPLOYEE ID:	SECTION/DEPT:
LEAVE BALANCE AT LAST PAY PERIOD: VACATION: SICK TIME:	HIRE DATE:	E-MAIL ADDRESS:

I hereby request to receive donated leave under the Fermilab Vacation Donation Program. I certify the following:

- I am unable (or expect to be unable) to perform my job duties due to a non-occupational medical emergency as defined in the Fermilab Vacation Donation policy.
- I have been authorized by a health care provider to be absent from work due to this condition.
- I will have exhausted all leave balances. Without a donation, I will be off work at least two weeks without pay.
- I am not currently receiving disability benefits.
- I have read the Fermilab Vacation Donation policy.

Applicant should check only one of the following two options:

- I authorize my name, section/group, and nature of medical emergency to be advertised in the solicitation notice.
- I authorize my name and section/group to be advertised in the solicitation notice, but **do not** authorize the release of the nature of my serious medical emergency.

I would like the following department/section/building/floor/others to be included in the solicitation notice:

I authorize the Fermilab Vacation Donation "on-call" distribution list to receive my solicitation notice.

By submitting this application, you consent to the release of pertinent medical facts to document your serious medical emergency. You may refuse to sign this authorization. However, if you refuse, you will not be permitted to participate in the Vacation Donation Program. You have the right to revoke this authorization, in writing, at any time except to the extent that Fermi National Accelerator Laboratory or its authorized representatives have taken action in reliance on it.

You hereby waive any right of access provided by law (including the Privacy Act of 1974, 5USC 552a) to information or records concerning the persons who donate leave for your use in response to this application. You understand that there are no guarantees as to the number of hours of leave that will be donated, as participation in this program is strictly voluntary. You understand any donated leave received is included in your gross income, considered "wages," and taxed accordingly per Internal Revenue Service, Letter Ruling 9051005.

This authorization shall expire upon the earlier occurrence of: revocation of the authorization by you or completion of the medical emergency. This form will be retained by Fermilab for a period of one year from the date the leave transfer is executed.

APPLICANT'S SIGNATURE*

DATE

**An immediate family member may complete this form if the employee is incapacitated.*

FOR USE BY HUMAN RESOURCES ONLY:

REQUEST APPROVED: <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE PROCESSED:
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