



Agency: Provide a copy of the final approved/disapproved form to the employee.

EMPLOYEE INFORMATION

Employee name	Employee ID	Hire date
Agency name	Agency number	Work location

REQUEST INFORMATION AND EMPLOYEE SIGNATURE (check all that apply)

I request approval to receive donated leave. I certify I am eligible for and require donated leave as authorized by 74 O.S. § 840-2.23 State leave-sharing program eligibility – Leave of Last Resort Bank.

☐ **Option 1: Request leave from another agency.**

I affirm I have exhausted all annual and sick leave and am unable to receive donated leave within my agency.

☐ **Option 2: Use the HCM online Shared Leave Registry.**

I understand that my first name, last initial and agency information will be placed on the Shared Leave Registry.

I understand that this information will be available for review by anyone having internet access, including individuals outside of state government and accept complete responsibility for and authorize this request.

☐ **Option 3: Request leave from Leave Bank.**

I affirm I have exhausted all annual and sick leave and all sources for shared leave both within my agency and other agencies, but I am unable to receive donated leave.

Employee signature	Date
--------------------	------

AGENCY VERIFICATION (check all that apply)

Agency contact name	Email	Phone
---------------------	-------	-------

Employee's annual and sick leave balances*

Annual hours:	As of date:	Sick hours:	As of date:
---------------	-------------	-------------	-------------

Previous shared leave usage (total hours):

Is the employee eligible and requiring leave due to a qualifying Family and Medical Leave Act occurrence? (§74-840-2.23(A.1))

☐ Yes ☐ No

Is the employee or a relative or household member suffering from an extraordinary or severe illness, injury, impairment, or physical or mental condition which may cause the employee to take leave without pay or terminate employment? (§74-840-2.23(A.2))

☐ Yes ☐ No

Is shared leave needed immediately after the death of a relative or household member (not to exceed five days in any calendar year) (§840-2.23(A.3))?

☐ Yes ☐ No

Is the employee on workers' compensation (Leave of Last Resort Bank only)? ☐ Yes ☐ No

Is the employee receiving disability (Leave of Last Resort Bank only)? ☐ Yes ☐ No

☐ Interagency shared leave request: I verify the employee has exhausted all annual/sick leave and is unable to receive donated leave within the agency.

☐ I authorize listing on the Shared Leave Registry.

☐ Shared Leave Bank of Last Resort request only: I verify the employee has exhausted all annual/sick leave and is unable to receive donated leave through any available channels.

*GRDA agency 980 must submit with this form a Workday screenshot of current leave balances of the employee.

SIGNATURES

Signature of agency verifying official

Date

☐

Approved

☐

Disapproved

Signature of appointing authority

Date

☐

Approved

☐

Disapproved

OMES USE ONLY

Signature of HCM Statewide HR consultant

Date