NORTHEAST MARYLAND WASTE DISPOSAL AUTHORITY

LEAVE DONATION POLICY
(effective April ___, 2025)

1. STATEMENT OF POLICY

The Authority's Leave Policy allows staff to voluntarily donate available leave hours (vacation, sick, and compensatory time) to another NMWDA employee who has exhausted all annual, personal, sick (including accrued leave) and compensatory leave because of a prolonged medical condition or a catastrophic illness or injury of a member of the employee's immediate family for whom the employee is needed to provide direct care. The Authority's Leave Policy (including the forms utilized) follows the State of Maryland Leave Donation Policy which provides for Employee-to-Employee Leave Donation Programs (See MD State Personnel and Pensions Code, Secs. 9-605 – 9-606 (2024).

2. DONORS OF LEAVE

Donors of leave must (i) maintain a sick leave balance of at least 225 hours (adjusted from 240 hours to accommodate the NMWDA 7.5 hour work day as opposed to the State's 8 hour workday) after the donation is deducted; (ii) designate the recipient of the leave and (iii) shall have any unused donated leave restored by their Appointing Authority. Donors are not taxed on the donation, and may not claim an expense, charitable contribution, or loss deduction for any leave donated. Donors must complete the donation form attached.

3. RECIPIENTS OF LEAVE

Employees receiving donated leave must apply for the donation by completing the forms provided and attached. Recipients of donated leave (i) must have exhausted all annual, personal, sick (including accrued leave) and compensatory leave because of a prolonged medical condition or a catastrophic illness or injury of a member of the employee's immediate family for whom the employee is needed to provide direct care; provide a certificate of illness or disability; (ii) must receive less than 1,950 hours (adjusted from 2,080 hours to accommodate the NMWDA 7.5 hour work day as opposed to the State's 8 hour workday) of leave from donation, and (iii) must be in good standing as an employee. Donated leave hours are considered wages of the recipient, unless excluded by a specific provision of the IRS. Receipt of leave must be at the recipient's standard pay rate, not the donor's pay rate.

4. DESIGNATION OF APPOINTING AUTHORITY

The Executive Director designates the Director of Administration and Contracts as the "Appointing Authority" for the NMWDA donations (unless the Director of Administration and Contracts is requesting to receive a donation, in which case the Executive Director will be the Appointing Authority). The Executive Director may change the designation of the "Appointing Authority," and will notify employees of any changes of designation. The Executive Director may review any request under the Leave Donation Policy and is authorized to deny the donation of any hours that do not comply with the applicable guidelines. Employees may appeal a denial of donated leave. Such appeal should be directed to the Executive Director, include a written statement of why the denial should be overturned, and may include supporting documentation.

5. TRACKING OF DONATED HOURS

Accounting will track and work with the Director of Administration and Contracts to implement the tracking for any donated hours. Donated hours for specified employees will go into a pool and be tracked for that employee. The hours needed for the recipient will be deducted equally from any and all donors, as needed by the recipient. Once the employee returns to work, any unused hours will be returned to the applicable donor. Leave donations and related medical information are confidential.

6. FORMS

The forms for donating leave, receiving donated leave, the medical certification form for recipient of donated leave, and authorization to release medical records for recipient of donated leave are attached.

Please contact Accounting and/or the Director of Administration and Contracts with any questions.

Attachments

EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM - REQUEST FORM

W# of **Donating Employee***:

Hire Date:

Name of **Donating** Employee*:

** Your **full** Name and Workday Number (W#) are required to help verify your identity. Failure to provide it may result in delays and/or rejection of this request. This information is kept confidential.*

RECEIVING EMPLOYEE'S INFORMATION:

Name of Employee:

Employee's W#:

TYPE OF LEAVE DONATED:	**TOTAL HOURS DONATED:**	**LEAVE BALANCE AFTER DONATION:**
[ ] SICK**		
[ ] ANNUAL		
[ ] PERSONAL		

I understand that if the employee to whom I am donating leave does not use the leave for any reason***, the unused donated leave shall be returned to my leave balances by my Appointing Authority.***

Signature: **Date:**

**** If you are donating sick leave, you must maintain a balance of at least 225 hours of sick leave after the donation is deducted.**

ANNUAL/PERSONAL LEAVE CERTIFICATION: I have reviewed this employee's leave balances and affirm that s/he/they has sufficient annual/personal leave to make this donation.

SICK LEAVE CERTIFICATION: I have reviewed this employee's sick leave balance. **I affirm that s/he/they will have a sick leave balance of at least 225 hours after this donation.** As the Appointing Authority/Designee for the employee making the above leave donation, I certify this donation is in compliance with the Northeast Maryland Leave Donation Policy.

_____ _____

APPOINTING AUTHORITY/DESIGNEE DATE

*(**If the receiving employee is denied** the use of donated leave, the appointing authority shall notify the donating employee within 7 days of the denial, and the appointing authority **shall restore the leave balance of the donating employee** within 14 days of notification.)*

********************NOT VALID WITHOUT TIMEKEEPER CERTIFICATION********************

Hours of selected LEAVE DONATED were deducted from balance on _____ by _____/_____ Print Name/Initials

EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM - REQUEST FORM

Name: _____

Home Address:

_____

Workday #: W ___ ___ ___ ___ ___ ___ ___

** Your full Name and Workday Number (W#) are **required** to help verify your identity and process your Request. Failure to provide it may result in delays and/or rejection of your request. This information is kept confidential.*

Request Type: ☐ New ☐ Extension

Reason for Request:

☐ An illness or disability of the employee due to *a serious and prolonged medical condition that existed at the time the leave was donated*; **or**

☐ A catastrophic illness or injury of a member of the employee's immediate family for whom the employee is needed to provide direct care**.

****For family member please provide - Name: Relationship:** _____

****Describe care to be provided:**

_____

_____

_____

Signature: _____

Date: _____

MUST BE COMPLETED BY APPOINTING AUTHORITY/DESIGNEE

As the Appointing Authority/Designee for the employee receiving the leave donation, I certify that this employee has exhausted all forms of annual, sick, personal and compensatory time because of a serious and prolonged medical condition. Approval will not cause the employee to exceed 1950 hours of leave from the Employee-to-Employee Leave Donation Program during his/her entire employment with the Northeast Maryland Waste Disposal Authority. Approval will not cause the employee to exceed 1950 hours of continuous leave, when combined with all other forms of paid leave.

As the appointing authority or designee for this employee, I have reviewed the employee's records and I certify that this request meets all of the criteria specified in this Section.

Signature of Appointing Authority or Designee:

_____

Name:

Date: _____

NMWDA EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM
MEDICAL CERTIFICATION FORM

TO BE COMPLETED BY TREATING PHYSICIAN

EMPLOYEE'S NAME:

PATIENT'S NAME (if not employee):

DIAGNOSIS(ES):

ICD 10 CODE(S) (Required):

SUMMARY OF TREATMENT(S) & PROCEDURE(S):

START DATE OF CURRENT INCAPACITY:

SURGERY DATE (IF APPLICABLE):

HOSPITALIZATION DATE(S) (IF APPLICABLE):

FROM: TO:

DATE EMPLOYEE IS LIKELY TO RETURN TO **FULL DUTY** (**REQUIRED**):

_____

****

PLEASE COMPLETE THIS SECTION ONLY IF EMPLOYEE CAN RETURN IN A MODIFIED CAPACITY

MODIFIED RETURN DATE (IF APPLICABLE): _____

PROVIDE RESTRICTIONS FOR MODIFIED DUTY **(REQUIRED WITH A MODIFIED DATE)**:

_____

_____

****

PHYSICIAN'S NAME (PRINT)

_____

PHYSICIAN'S PHONE NUMBER: _____

PHYSICIAN'S SIGNATURE (REQUIRED)

_____

DATE FORM COMPLETED: _____

(PLEASE ATTACH REQUIRED MEDICAL VERIFICATION OF SURGERY)

Failure to provide sufficient medical documentation may delay the processing of this request.

This information shall be treated as a confidential medical record.

NORTHEAST MARYLAND WASTE DISPOSAL AUTHORITY LEAVE DONATION PROGRAM

AUTHORIZATION FORM FOR REVIEW OF RELEASED RECORDS AND INFORMATION

A. Identification: This document authorizes the use and/or disclosure of confidential protected health information about the following person; **this document is not used to request additional medical records or information on the patient's behalf.**

Employee's Name:

Date of Birth:

Patient's Name (if not the employee):

Date of Birth:

B. Directions for Release:

I authorize the individual or company identified below in Section B.1b to release and/or use protected health information pertaining to the individual listed in Section A to the individual(s) identified in Section B.1a.

B.1a. I authorize the disclosure of information to:

O My Appointing Authority or Designee

O Northeast Maryland Waste Disposal Authority Leave Donation Program

B.1b. I authorize the release of information from:

O (Specify Health Care Provider) _____

B.2. Information to be released: I authorize the disclosure and/or use of any information from my medical records relating to the condition(s) for which I am seeking leave.

B.3. Purposes: I authorize the disclosure and/or use for the following reason(s):

(a) to determine my eligibility for leave from the Northeast Maryland Waste Disposal Authority Leave Donation Program

B.4. I am asking that you NOT provide any genetic information when responding to this request for medical information. Genetic information, as defined by the Genetic Information Nondiscrimination Act of 2008, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or

an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

C. Right to Revoke: I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance upon it. This authorization will expire one year after the date it is signed. To revoke the authorization, I must contact, in writing: Executive Director, Northeast Maryland Waste Disposal Authority.

D. Authorization and Signature: I authorize the **review** of my confidential protected health information, as described in my directions in Section B. I understand that this authorization is voluntary, the information to be disclosed is protected by law and the disclosure will conform with my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws limiting the use and/or disclosure of my confidential protected health information.

I have read the contents of this authorization and I confirm that the contents are consistent with my directions.

*I understand that by signing this form, I am authorizing the **review** and/or disclosure of my confidential protected health information for determining my eligibility for leave.*

_____

Employee Signature/ Patient Signature (if not employee)

Date: