CD-037200 Voluntary Donation of Annual Leave	Issued: 2/28/90 Effective: 2/28/90	Reviewed: 10/31/20 Revised: 3/9/17
Alisha Tafoya Lucero, Cabinet Secretary		***Original Signed and Kept on File***

AUTHORITY:

State Personnel Board Rule 1.7.7.9 NMAC.

REFERENCE:

Department of Labor Forms, Family and Medical Leave Act, 29 U.S.C. Sec 2601: http://webapps.dol.gov/libraryforms

PURPOSE:

To provide guidelines for the voluntary donation of annual leave by Corrections Department employees to other Corrections Department employees in an attempt to minimize financial hardships during medical emergencies.

APPLICABILITY:

All Corrections Department employees who meet established eligibility criteria.

FORMS:

A. **Annual Leave Donation Disclosure** form *(CD-037201.1)*
B. **Donation of Annual Leave for Medical Emergency** form *(CD-037201.2)*
C. **Certification of Health Care Provider for Employee's Serious Health Condition** form WH-380E United States Department of Labor (4 Pages)

ATTACHMENTS:

A. **Medical Certification Definitions** Attachment *(CD-037201.A)* (2 pages)
B. **Voluntary Donation of Annual Leave Criteria Checklist** Attachment *(CD-037201.B)*
C. **Sample Format** Attachment *(CD-037201.C)*

DEFINITION:

A. *Eligible Employee*: An employee who has completed their probationary period.

B. *Medical Emergency*: A circumstance where all of the following factors exist: 1) the employee, their spouse, child and/or parent has a medical condition that will require the employee's full-time absence from duty for a minimum of two weeks; 2) the employee has exhausted all forms of paid leave; 3) the medical condition is severe or life threatening in nature.

POLICY:

A. When a Department employee, their spouse and/or domestic partner, child and/or parent/domestic partner's parent is experiencing a medical emergency, the Department may allow employees to donate annual leave to the employee experiencing the medical emergency. Requests involving other family members will be considered on a case-by-case basis when the employee is able to provide documentation that they are the primary caregiver.

B. Each request to declare a medical emergency will be evaluated on its own merits. Factors such as nature and severity of the medical condition, previous leave use patterns and circumstances for leave, length of service, duration of medical condition, etc., shall be considered.

C. Other factors to be considered include the effect that granting additional leave will have on the budget and operations of the Corrections Department or unit (e.g. the need to cover the vacancy with overtime, etc).

D. Due to the staff intensive nature of corrections work, each request will be highly scrutinized and a maximum of 400 hours (ten weeks) may be received by any one individual during a one-year period.

E. The Secretary or designee may grant exceptions to the policy based on the nature of the medical emergency on a case-by-case basis.

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AUTHORITY:

Policy *CD-037200*

PROCEDURES:

A. The employee who wishes to be the leave recipient shall submit a written request to the appropriate human resource representative. The written request shall specify the nature of the medical condition and the expected date of return. A **Certification of Health Care Provider for Employee's Serious Health Condition** form WH-380E shall accompany the request. In the event that the employee is unable to submit a request on his/her behalf, another party may initiate the request.

B. The Warden, Region Manager or Division Director, or a designee, will review and verify the request meets the eligibility criteria by completing the **Voluntary Donation of Annual Leave Criteria Checklist** Attachment *(CD-037201.B).*

C. Requests that do not meet the eligibility criteria as established by the medical emergency definition shall be disapproved by the Warden, Region Manager, Division Director, or their designee and returned to the employee with an explanation for the rejection.

D. Requests that meet the eligibility criteria outlined in the medical emergency definition shall be forwarded to the Human Resource Bureau along with a recommendation using the **Sample Format** Attachment *(CD-037201.C).*

F. The Human Resource Bureau will send all rejected requests back to the originating human resource representative with reasons for rejection. The Human Resource Bureau shall notify the employee in writing of the decision with an explanation for the rejection.

G. The Human Resource Bureau shall forward requests that are approved by the Secretary to the originating human resource representative who will notify the employee of the decision.

H. The originating human resource representative will inform other employees (through e-mail or payroll attachment) that a medical emergency exists and that employees who wish to donate annual leave hours shall complete an **Annual Leave Donation Disclosure** form *(CD-037201.1).* Individual solicitation of annual leave donations is prohibited. However, employees may voluntarily donate leave to employees with a medical emergency.

I. A completed **Donation of Annual Leave for Medical Emergency** form *(CD-037201.2)* shall be forwarded to the Central Office Human Resource Bureau for final approval in accordance with this policy.

J. Upon approval of the Central Office Human Resource Bureau of the **Donation of Annual Leave for Medical Emergency** form *(CD-037201.2)*, the actual transfer of leave shall be coordinated by the respective payroll officer.

K. Donated leave shall revert to the employees who donated leave on a prorated basis when the medical emergency ends or the employee separates from the agency.

L. Deviations of this process shall not be made without the prior approval of the Human Resource Bureau Chief.

Form CD-037201.1
Revised 03/09/17

NEW MEXICO CORRECTIONS DEPARTMENT
Annual Leave Donation Disclosure

I,_____, donate_____hours of annual leave to_____.
(Print Name) (Print Name)

I understand that any annual leave remaining at the end of the emergency shall be returned to donors on a prorated basis.

_____ _____
Employee Signature Date

_____
Employee ID #

_____
Division/Institution

Form CD-037201.2
Revised 03/09/17

NEW MEXICO
CORRECTIONS DEPARTMENT
Donation of Annual Leave for Medical Emergency

INCUMBENT'S NAME:_____SSN:_____

DIVISION/INSTITUTION: _____

Approved on: _____
(Date)

Donor	SSN	Hours of Donated Leave	Donor's hourly Pay Rate =	Dollars Donated

Total Dollars Donated:

Total Dollars Donated	Divided by Recipient's Hourly Rate=	Hours of Donated Leave

* Maximum 400 hours

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

NEW MEXICO
CORRECTIONS DEPARTMENT
Medical Certification

A "Serious Health Condition" means an illness, injury, impairment or physical or medical condition that involves one of the following:

1. *Hospital Care*: Inpatient is (i.e., an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. *Absence Plus Treatment:* A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   (a) Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under order of, or on referral by, a health care provider; or

   (b) Treatment by a health care provider on at least one occasion, which results in a regimen of continuing treatment under the supervision of the health care provider.

3. *Pregnancy*: Any period of incapacity due to pregnancy, or for prenatal care.

4. *Chronic Conditions Requiring Treatments*: A chronic condition which:

   (a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   (c) May cause episodic, rather than a continuing, period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. *Permanent/Long-Term Conditions Requiring Supervision*: A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke or the terminal stages of a disease.

Medical Certification
(Continued)

6. *Multiple Treatments (Non-Chronic Conditions)*: Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity or more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation or treatment, such as cancer therapy), kidney disease (dialysis).

   Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examination, or dental examinations.

   A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise and other similar activities that can be initiated without a visit to a health care provider.

Attachment CD-037201.B
Revised 03/09/17

NEW MEXICO
CORRECTIONS DEPARTMENT
Voluntary Donation of Annual Leave Criteria Checklist

Name:_____ SS#: _____

Requesting Facility/Division: _____

Eligibility Criteria:

- Does the employee (not a family member) have a medical condition that will require full time absence from duty for a minimum of two weeks?

  ☐ Yes ☐ No

- Has the employee exhausted all forms of paid leave? If not, when will the employee do so?

  ☐ Yes_____(date all leave was exhausted)
  ☐ No, employee will exhaust all leave on_____(date).

- Is the medical condition severe or life threatening in nature?

  ☐ Yes ☐ No

- Is a copy of the Medical Certification Form completed by the employee's physician attached?

  ☐ Yes ☐ No

Based on the above information, the recommendation is: Approved / Disapproved

_____ _____
Warden/Division Director Date

If disapproved, reason(s) for disapproval: _____
_____
_____
_____
_____

Attachment CD-037201.C
Revised 03/09/17

NEW MEXICO
CORRECTIONS DEPARTMENT
Sample Format

To: Deputy Cabinet Secretary

Thru: Human Resource Bureau Chief

From: Warden or Division Director

Date: Date

RE: Voluntary Donation of Annual Leave for _____
(Employee)

I have reviewed the circumstances surrounding the request for voluntary donations of annual leave for _____And have determined that he or she meets the eligibility criteria as
(Employee)
outlined in *CD-037200*. Following is information relative to his or her request and employment history.

Nature of medical condition:

Date of Hire:

Leave balances at the time the medical condition commenced:

Has the employee been evaluated for light duty status?