UNIVERSITY OF OREGON

Application for Hardship Leave (Teamsters)

University of Oregon – Human Resources
677 East 12th Ave., Ste. 400 – 5210 University of Oregon
Eugene OR 97403-5210
541-346-3159 – fax: 541-346-2548

Employee Request

Employee Name: _____ **UO ID:** _____

Leave Begin Date: _____ **Leave End Date:** _____

I request to use "Hardship Leave" in accordance with Article 24, Section 5 of the ***Teamsters Local Union #206*** Labor Agreement.

I read and understand that application for hardship leave shall be in writing and sent to the University's Human Resource Department, accompanied by the treating physician's written statement certifying that the illness or injury will continue for at least thirty (30) days following the projected exhaustion of my accumulated leave. If a Certification of Physician or Practitioner form is on file with the HR Medical Leaves Coordinator for FMLA/OFLA leave and it's for the same condition with the above information. A new form will not be required. Accumulated leave includes vacation and compensatory leave accruals.

I understand the following:

- Use of donated leave begins once accrued leave has exhausted.
- Donations shall be credited at my current regular hourly rate of pay.
- I am not eligible to receive/use Hardship Leave if I am eligible for or receiving disability benefits, workers' Compensation, or on parental leaves.
- In cases of intermittent leave, donated leave will be accessed after all accumulated leave is exhausted. Accumulated leave includes vacation and compensatory leave accruals.

Applicant's Signature: _____ **Date**: _____

Your phone number or email address - (for your union representative to contact you): _____

Department Payroll Administrator

I certify that the employee leave balances are as follows:

Date Sick Leave Exhausted	Date Vac Leave Exhausted	Date Comp. Time Exhausted	Date Pers. Time Exhausted

Department's Pay Period: From _____ To _____

Print Name: _____ **Phone:** _____

Payroll Administrator's signature: _____ **Date:** _____

HR Internal Use

Donator Rate of Pay	PEALEAVE / Date	Recipients Rate of Pay	Total Sick Leave Hours Donated	HR Representative & Date

Teamsters Local Union #206 - Article 24, Section 5: Hardship Leave

Each Institution will allow employees within the bargaining unit to make irrevocable donations of accumulated vacation leave or compensatory time for use by eligible bargaining unit recipients in that Institution as sick leave. Hardship leave donations will be administered under the following stipulations and shall be strictly enforced with no exceptions.

a) The recipient and donor must be regular employees of the Institution.

b) The Employer shall not assume any tax liabilities that would otherwise accrue to the employee.

c) Use of donated leave shall be consistent with the other Sections of this Article.

d) Applications for hardship leave shall be in writing and sent to the Institution's Human Resource Department and accompanied by the treating physician's written statement certifying that the illness or injury will continue for at least thirty (30) days following donee's projected exhausting of the accumulated leave. Donated leave may be used intermittently.

e) Accumulated leave includes vacation and compensatory leave accruals.

f) Donations shall be credited at the recipient's current regular hourly rate of pay.

Donations shall be used to reimburse the Institution for such costs as are incurred for insurance contributions pursuant to Article 8 for which the recipient is eligible to receive as a result of his/her use of donated hardship leave.

g) Employees otherwise eligible for or receiving disability benefits, workers' compensation, or on parental leaves will not be considered eligible to receive donations under this agreement.

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Certification of Physician or Practitioner

If this leave is covered under FMLA/OFLA, certification by a physician may have already been submitted.

1. Employee Name: _____
2. Family Member/Patient's Name: _____
3. Date patient/employee condition commenced: _____
4. Probable duration of patient/employee incapacity: _____

Please select one:

☐ I certify that the employee will be needed to care for

(Family Member name) _____

From: (date)_____to: (date) _____

☐ I certify that (employee)_____will be totally incapacitated

from: (date)_____to: (date) _____

☐ I certify that (employee) _____will be partially incapacitated

from: (date)_____to: (date) _____

(Physician's Name & Address) _____

(Physician's signature) _____(date) _____

Submit the completed application with certification to:

Human Resources
Medical Leaves Coordinator
5210 University of Oregon
Eugene OR 97403-5210
Telephone: (541) 346-2950
Fax: (541) 346-2548
E-mail: HRLeaves@uoregon.edu