STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

REQUEST TO APPEAL FORM - FOR DENIAL OF LEAVE

(ALL FIELDS ARE REQUIRED)

NAME: _____ **DATE:** _____

HOME ADDRESS: _____

PERSONAL EMAIL: _____ **W#:** _____

JOB TITLE AND SUMMARY OF DUTIES:

_____

AGENCY NAME: _____ **LAST DAY WORKED:** _____

REQUEST IS FOR: EMPLOYEE ☐ **; OR,**

FAMILY MEMBER ☐ **FAMILY MEMBER NAME**: _____

My request for Employee-to-Employee leave should be reconsidered because:

In addition to submitting your appeal, please have your treating physician(s) fax or email any additional medical records that support your Employee-to-Employee Leave Appeal. The medical documentation should address only the period of time you are appealing. It must include detailed information that explains the severity and duration of your (or your family member's) medical condition(s). Please refer to the State Employee-to-Employee Leave Donation Program – Medical Documentation sheet you received with your denial letter for examples of the types of documentation that should be provided.

The appeal and the records may be emailed or faxed. Please follow the instructions in your denial letter.