Delaware Department of
Human Resources

DL-1 REQUEST FOR DONATED LEAVE FORM	
DHR-STW-Form #: DHR-STW-402.1-F1	**Authority: 29 Del. C. § 5956**
Effective Date: September 10, 2024	**Revision Date: September 10, 2024**
Supersedes: DL-1 Request for Donated Leave 12/2017.	

Part 1: Employee Information – Completed by Employee or Designee

Employee Name (Last, First, MI):____

Employee ID: ________________________________ Date of Birth:_______________________

Mailing Address (Street, City, State, Zip): ____

Agency (Name and Location): ____

Date of Hire:___________________________ Telephone Number:_______________________

Illness[1] of (check one) ☐ Employee ☐ Family Member

Family Member's Name: _________________________ Relationship to Employee: __________

Family Member's Address (Street, City, State Zip): ____________________________________

The following questions must be answered for employee or impacted family member.

Date of Accident/Illness: _________________

Date Disability Began:______________ Expected Returned to Work Date:_________________

Nature of Illness/Injury (Brief Description – no diagnosis due to GINA and ADA):

____

Date Treatment Began: _______________ Name of Treating Physician: ___________________

Physician's Telephone Number: ______________________________

Physician's Address (Street, City, State Zip):

____

List any other income you are receiving or are eligible to receive as a result of your disability.

(Example: Social Security, Worker's Compensation, Disability Insurance, Pensions, etc.):

____

[1] *Illness is defined as any illness or injury to the employee or to a member of an employee's family which is diagnosed by a physician and certified by the physician as rendering the employee or the member of the employee's family unable to work; or in the case of family member who does not work, the equivalent of "unable to work" for a period greater than 5 calendar weeks or the equivalent in separate 7 calendar days or full calendar week periods resulting from the same or related medical condition and occurring within the same 12 consecutive month period.*

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, medical institution, pharmacy, governmental agency, or my present employer having information concerning me, to release said information to the State of Delaware or its designated representative to be used for determination of my eligibility for Donated Leave.

This authorization shall be valid from the date signed through the duration of this claim.
In order to be eligible to receive Donated Leave beyond 30 days, I will resubmit a certification from my treating physician certifying continued disability/illness.

Name of Individual Completing DL-1 (If applying on behalf of Employee): ___________________
Relationship to Employee: ____________________ Telephone Number: ___________________

I request that I be allowed to receive donated leave under the State of Delaware Donated Leave Program. I certify that (1) I have been a State Officer or employee for at least 6 months prior to the request; (2) I have used all of my sick leave and one-half of my annual leave; however, for the illness of a family member, I certify that I have used all of my sick and annual leave; (3) I have established medical justification for such receipt, which must be renewed every 30 days.

☐ I certify that the above statements are true.

____ _____________________

Employee Signature or Individual Applying on Behalf of Employee Date

☐ By using this form, the parties acknowledge their agreement to conduct transactions by electronic means. A party's electronic signature for purpose of the Uniform Electronic Transactions Act, 6 *Del. C.* Ch. 12A may be provided by checking a box as indicated, electronic initials or name, or email confirmation.

Part 2: DHR Representative of Agency – including DHR-centralized staff

Date Employee Employed by the State for 6 months: ________
Employee's last date worked: _________________
Date all Sick Leave will be/was Exhausted: ___________
Date One-Half Annual Leave, or all annual leave if the request is for a family member, will be/was Exhausted: ___________
Date all Annual Leave will be/was Exhausted:_________________

Date FMLA Began: ________________________ Date Disability Began: _____________________

Date FMLA Approved Through: _______ Date Short Term Disability Approved Through: _______

Recipient's HR Representative's Recommendation: ☐ Approve ☐ Deny

HR Representative Name: _____________________________________ Date: _______________

HR Representative Signature: ________________________________ Date: _______________

Recipient's Agency/Division: ____

Agency/Division Address/SLC: ____

Part 3: Completed by Employee Engagement (Leave Bank Requests Only)

☐ The donated leave bank request has been reviewed by Employee Engagement to determine if the employee meets all the criteria for the Donated Leave program.

Employee Engagement Recommendation: ☐ Approve ☐ Deny

Approval Granted Through: ____________ # of Donated Leave Hours Approved: ____________

Part 4: Completed by DHR Secretary or Designee (Leave Bank Requests Only)

I have received this application and I hereby ☐ Approve ☐ Deny ______________________ for the receipt and use of donated leave. Further, based upon the recommendation of Employee Engagement, I am authorizing transfer of ______ hours from the State Donated Leave Bank to ____________________________.

______________________________________ ______________________

Signature, DHR Secretary or Designee Date

Part 5: Completed by DHR Representative of Agency – including DHR-centralized staff

I further certify that the applicant has been credited with ______ of Donated Leave from the State of Delaware Donated Leave Bank.

Agency HR Name: ______________________________________

Agency HR Signature: ____________________________________ Date: ____________________

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ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY - CONFIDENTIAL

Part 1: Completed By Employee or Designee

Patient Name: ______________________________________ Patient DOB: ________________

Present Address (Street, City, State, Zip):

____

Patient's Relationship to Employee: ☐ Self ☐ Family Member (designate):_____________

Type of Leave Being Requested:

☐ Donated Leave for Self ☐ Donated Leave for Family

Employee Name: _________________________Employee Signature: _____________________

To qualify for the Donated Leave program, I must provide my Agency Human Resources Office with a physician's statement detailing the start date of my catastrophic illness or injury, a description of the condition, a recovery prognosis, and the estimated date of my return to work. To meet this requirement, I kindly request that you complete the form below and return it to me at your earliest convenience.

Part 2: Completed by Treating Physician

Notification to Healthcare Provider

Title II of the Genetic Information Nondiscrimination Act (GINA) "prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you do NOT provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic test, the fact that an individual or an individual's family member sought or receive 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."

Patient was ☐ Under my Professional Care From: ______________ To: _______________

☐ Hospitalized From: _______________ To: _______________

Dates of Treatment: ____

Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify) ____________________

Date Symptoms or Disability Began: ___________________________________

Is Condition Due to Serious Illness or Injury Arising out of Patient's Employment:_____________

Period of Incapacity From: ____________ To: _________________

During this time, will or did the patient need care? ☐ Yes ☐ No

If yes, explain the care needed by the patient and why such care is/was medically necessary.

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EMPLOYEE LIMITATIONS/RESTRICTIONS (skip if patient is a family member of the employee)
Patient was or may be able to resume full duty employment, with no restrictions in work activities,

on: ___________________.

If unable to presently return to full duty employment, can the patient return to less than full duty?
☐ Yes ☐ No
If yes, what is the period of partial incapacity? From: _______________ To: _________________

Describe in detail any limitations or restrictions on the ability of the employee to work. List any assistive devices or equipment, or any accommodation the employee requires to perform his/her job.

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☐ I hereby certify that the above information is, to the best of my knowledge and understanding, correct and true as of the date of the signature below.

Physician's Signature: ___________________________________ Date: ___________________

Printed Name: ________________________________ Phone Number: __________________

☐ By using this form, the parties acknowledge their agreement to conduct transactions by electronic means. A party's electronic signature for purpose of the Uniform Electronic Transactions Act, 6 *Del. C.* Ch. 12A may be provided by checking a box as indicated, electronic initials or name, or email confirmation.

A copy of this completed Agreement must be sent to the Agency Human Resources Office.