STATE OF WEST VIRGINIA
APPLICATION FOR
ORGAN DONATION/TESTING LEAVE WITH PAY

NAME:

WORK UNIT/SECTION: | **DIVISION:**

I AM MAKING APPLICATION FOR THE FOLLOWING LEAVE:

_____ Hours for:
- ❑ Adult Kidney Donation
- ❑ Adult Liver Portion Donation
- ❑ Adult Bone Marrow Donation

_____ Hours for pre-operative testing to determine surgical fitness and compatability.

PERIOD OF LEAVE:

FROM Date: _____ _____ A.M. P.M.

TO Date: _____ _____ A.M. P.M.

EMPLOYEE SIGNATURE: | **APPLICATION DATE:**

❑ Approved **IMMEDIATE SUPERVISOR SIGNATURE:**

❑ Disapproved **DATE:**

❑ Approved **AGENCY-AUTHORIZED SIGNATURE:**

❑ Disapproved **DATE:**

REMARKS(if necessary):

NOTE: This form is to be used **only** when an employee is requesting paid leave for the purpose of making an organ donation as set forth in *WV Code* §29-6-28. This request must be accompanied by the Physician's/Practitioner's Statement for Organ Donation (DOP-L7).

Employees must use the Physician's/Practitioner's Statement (DOP-L3) when requesting regular sick leave, and the Physician's/Practitioner's Certification (DOP-L4) for leave under the State Parental Leave or federal Family/Medical Leave Acts.

STATE OF WEST VIRGINIA
PHYSICIAN'S/PRACTITIONER'S STATEMENT
FOR ORGAN DONATION

PATIENT'S NAME: | **EXAM DATE:**

PATIENT WAS:

❑ Under my professional care FROM _____ TO _____

❑ Hospitalized FROM _____ TO _____

PERIOD OF INCAPACITY DUE TO ORGAN DONATION/PRE-OPERATIVE TESTING:

FROM Date: _____ **TO** Date: _____

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 If yes, what is the period of partial incapacity?

❑ NO FROM _____ TO _____

ABSENCE DUE TO:

❑ Pre-operative Testing ***and/or***

Organ Donation: ❑ Adult Liver Portion ❑ Adult Kidney ❑ Adult Bone Marrow

LIMITATIONS/RESTRICTIONS:

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

Will this disability permanently prevent the employee from performing his/her duties?

❑ YES ❑ NO

PHYSICIAN/PRACTITIONER INFORMATION:

NAME: TELEPHONE:

ADDRESS:

SIGNATURE:

NOTE: This form is to be used **only** when an employee has made an organ donation as set forth in *WV Code* §29-6-28. Employees must use the Physician's/Practitioner's Statement (DOP-L3) when requesting regular sick leave, and the Physician's/Practitioner's Certification (DOP-L4) for leave under the State Parental Leave or federal Family/Medical Leave Acts.