Form 25
July 2022

☐ **New** ☐ **Recertification**

STATE OF ALABAMA
PERSONNEL DEPARTMENT
REQUEST FOR DONATED LEAVE

Employee Name		**SSAN**	
Department			

GINA NOTIFICATION

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by GINA. To comply with GINA, we are asking that you not provide any genetic information when responding to this request for medical information, except in the form of family medical history to comply with the certification requirements of the Family and Medical Leave Act, State or local leave laws, or certain employer leave policies.

"Genetic information" as defined by GINA, includes an individual's family history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received 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.

I do hereby request donated leave under *Code of Alabama* §36-26-35.2. This request is due to the catastrophic illness/injury, maternity, or adoption referenced on the attached documentation and is needed in order to continue my compensation because my leave will have been exhausted prior to my return to work. Under the FMLA, if a qualifying illness exists, an employee's job is protected for 12 weeks. I understand that the receipt and/or use of donated leave does not protect an employee's job after the 12 weeks covered by the FMLA are exhausted. I understand that I shall not coerce, reimburse, or provide any form of compensation to any person who donates leave to me or on my behalf.

Beneficiary Employee: _____ Date: _____

Pursuant to the *Code of Alabama* §36-26-35.2, I request that our employee be approved for receipt of donated leave. A doctor's statement outlining the condition and treatment is attached. I authorize my agency to add the total hours donated after approval by State Personnel to the above beneficiary.

Beneficiary Appointing Authority: _____ Date: _____

Approved / Denied

State Personnel Director: _____ **Date:** _____

Donated Leave Approved / Denied: