


## Policy and Procedure

	ENTITY/HOSPITAL INTEGRIS	NUMBER SYS-HR-252
	MANUAL System HR Policy	EFFECTIVE DATE 5/07
	SUBJECT Application for Award of Donated PPL ATTACHMENT 1	REVISED 5/07, 1/14, 1/17, 11/19

### EMPLOYEE EMERGENCY RESOURCE FUND

#### APPLICATION FOR AWARD OF DONATED PPL

Date:	Name:
Employee ID#:	Address:
Work phone #:	City, State:
Home phone #:	Zip code:
Other contact #: (i.e. cell, pager, relative)	Personal Email Address:

Please review the following eligibility criteria as defined in the PPL Leave Sharing Policy, SYS-HR-252, before completing the Application for Award of Donated PPL.

In order to be a “Qualifying Employee”, an INTEGRIS employee must meet the following criteria:


- The employee must be a full-time employee of INTEGRIS.
- The employee must be experiencing a **medical emergency** or be involved in a **major disaster**.
- The employee must have already exhausted all of his/her accumulated PPL. In addition, if the employee’s condition qualifies the employee to use EIAB, the employee must also have exhausted any accumulated EIAB.
- The employee may not have received donated PPL from the Leave Sharing Bank at any time during the twelve (12) months prior to the date of his/her most recent application to the EERF.
- The employee must not be eligible for short term disability benefits.

Definitions:

**“Medical emergency”** includes a serious health condition as defined by the FMLA (Family and Medical Leave Act) experienced by an employee for a period greater than four (4) weeks that renders the employee unable to perform his or her regularly scheduled duties on either a regular or intermittent basis or a serious health condition, as defined by the FMLA, experienced by the spouse, child, or parent of an employee for a period greater than four (4) weeks for whom the employee must miss regularly scheduled work to care for on either a regular or intermittent basis.

**“Major disaster”** includes any natural or man-made disaster declared to be a “major disaster” by the President of the United States.

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**Please answer every question. If application is not completely filled out, your request may not be considered, or action upon your request may be delayed.**

Have you previously applied for donated leave from the Employee Emergency Resource Fund?

Check One:  Yes  No                      If yes, when? \_\_\_\_\_

How many donated PPL hours are you requesting? \_\_\_\_\_

Marital Status (Check One) :

Married  Single  Divorced  Separated  Widow

Shift: \_\_\_\_\_ Employment Status:  FT  PT  OPT

Hire Date: \_\_\_\_\_ Medical Emergency/ Major Disaster Start Date: \_\_\_\_\_

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_

Number of dependents living at home: \_\_\_\_\_

*\*Please list the age and relationship information for **all** dependents living at home below*

Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please explain why this request should be considered a “**medical emergency**” or how you have been affected by a “**major disaster**”? (Please consult the policy for definitions of “medical emergency” and “major disaster.”) Please include with your application documents that support your claim of a “medical emergency” or “major disaster.”

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How long do you anticipate this medical emergency / major disaster to continue? Explain. (You may attach additional sheets, if necessary.)

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Completed applications may be emailed to Michele.Kelley@integrisok.com, faxed to (405) 949-3685, or sent by interoffice mail (attn: Michele 001.7375).

Contact Michele Kelley at 405-212-2062 with any questions.

**For Committee Use Only:**

Date Presented to Committee: \_\_\_\_\_ Status: \_\_\_\_ Granted \_\_\_\_ Denied

Grand Total Hours: \_\_\_\_\_

Employee Notified: \_\_\_\_\_ By: \_\_\_\_\_