Compassionate Care Leave Request – Employee Form

City of Dallas

Applicant Information

Date: _____

Employee Name (First Last): _____

Employee Number: _____

Employee Department: _____

HR Partner for Department: _____

Address: _____

_____

Contact Number: _____

Alternative Contact Number: _____

(a) Purpose. Compassionate leave is intended for employees with a serious medical condition or injury that prevents the employee from performing any type of work and, due to the employee's medical condition, it is anticipated that the employee will not be able to return to work for at least 20 weeks.

(b) Eligibility. To be considered for compassionate leave, an employee must have exhausted all accrued leave balances, completed a minimum of one year of city employment, and accumulated a minimum of 40 hours of sick leave at any time prior to the occurrence of the condition for which the compassionate leave is requested. The employee must have applied for City-sponsored Long-Term Disability benefits and not be receiving other types of salary replacement payments.

(c) Maximum leave allowed. For employees who are approved for compassionate leave, the maximum amount of compassionate leave that may be awarded is 348 hours for a sworn employee in the emergency response bureau of the fire department, and 232 hours for any other employee. An employee may only be awarded compassionate leave once.

Required approval. An employee's request for compassionate leave must be approved by the employee's department director and the director of human resources. Specific procedures and requirements for the administration of compassionate leave are outlined in the administrative directives of the city.

All information included on this form will be confidential and will not be released by the City of Dallas or without the written consent of the employee.

Has the employee completed one year of employment with the City of Dallas? ☐ Yes ☐ No

Has the employee exhausted all accrued balances? ☐ Yes ☐ No

Has the employee accumulated a minimum of 40 hours of sick leave prior to the occurrence of the condition for which compassionate leave is requested? ☐ Yes ☐ No

Has the employee requested City-provided long term disability insurance benefits? ☐ Yes ☐ No

Does the employee have access to other types of salary or salary replacements? ☐ Yes ☐ No
If so, please explain:

Does the employee have a serious medical condition or injury that prevents the employee from performing any type of work and, due to the employee's medical condition, and it is anticipated that the employee will not be able to return to work for at least 20 weeks? ☐ Yes ☐ No
**Please see the physician's statement for verification.*

Has the employee received Compassionate Leave in the past? ☐ Yes ☐ No

Please submit this form with the physician's statement supporting request for Compassionate Leave to the employee's HR Partner.

HR Partner:

Please review, sign, and submit the request to the department director for approval and then forward to the Director of HR. When completed please send all documentation to CODEmployeePaidLeave@dallas.gov.

I have verified the above information: ☐ Yes ☐ No

HR Partner Name: _____ **HR Partner ID#:** _____

HR Partner Signature: _____ **Date:** _____

Department Director:

Please review and sign for approval and forward it back to the HR Partner for further processing.

I approve this request for leave: ☐ Yes ☐ No

Director Signature: _____ **Date:** _____

Human Resources Director:

Please review and sign for approval and forward it back to the HR Partner.

I approve this request for leave: ☐ Yes ☐ No

HR Director Signature: _____ **Date:** _____

When completed please send all documentation to CODEmployeePaidLeave@dallas.gov