PORTLAND COMMUNITY COLLEGE DISTRICT
LEAVE BANK TRANSFER APPLICATION

I, _____ (*name*), a current member of the Leave Bank Program, request a benefit in the form of compensated hours ("*Benefit*") under the Portland Community College ("*College*") Leave Bank Program ("*Program*") under the facts and for the medical necessity described below:

G#: _____ Employment Date: _____ Full-time ____ Part-time ____

Date Medical Leave of Absence Began: _____ Estimated Return Date: _____

Date Members Own Paid Leave is exhausted: _____

Benefit Requested: _____ (hours; if part-time, attach a copy of your work schedule)

Medical reason for this Benefit request (attach medical certification and PCC Request for Leave of Absence Form:
_____

I ___ am /___ am not currently receiving workers compensation and/or long term disability insurance benefits.

I ___ have / ____ have not been disciplined for any reason related to absences from work under the Classified or Faculty/Academic Professional Agreements within the last 12 months.

With respect to Program Benefits, I understand:

- this application will be reviewed by the Classified and Faculty/Academic Professional/Management Contract Administration Committees in accordance with the terms of the Program and the decision of the Committee is final;
- subject to hours availability, benefits are available for my medical necessity after I have been on medical leave of absence for at least two consecutive work weeks, and after I have exhausted all my own paid leave, and are limited to 350 hours during a consecutive 365-day period;
- if I receive a Benefit under the Program and it is later determined that I was ineligible for Program membership or if I am reimbursed for those same hours by a third party, I agree to reimburse the College for the dollar value of the Benefit.

The terms of the Program are set out in the Program document, a copy of which is available upon request from the College, and in the event of any discrepancy that document shall control over this form.

_____
Signature & Date

Return this form to: HR - Benefits – DC 3

To be completed by the Classified and Faculty/Academic Professional/Management Contract Administration Committees:

To: _____ Date: _____

Your request has been: ____ Approved for _____ hours ____ Denied

because:_____

by: _____
Contract Administration Committee
c: Employee
Contract Administration Committee
Payroll