KEAN UNIVERSITY
DONATED LEAVE PROGRAM
RECIPIENT AFFIDAVIT

1. I request participation in the Donated Leave Program (The specific nature of my illness will be kept confidential).

2. I have read the procedure regarding the donated leave program and I consent to participation in this program.

3. I certify that I have not offered anything of value to any employee in exchange for the donation of paid leave time to me.

4. I have not directly or indirectly intimidated, threatened or coerced any employee for the purpose of obtaining a donation of paid leave.

5. I have not interfered with any right which another employee may have with respect to contributing, receiving or using paid leave under this program.

6. I understand that I cannot receive temporary disability (TDI) benefits for the same periods that I am paid wages from donated sick and/or vacation leave or while using any of my own paid leave time.

7. I also understand that the Temporary Disability Benefits Law requires that I use all of the donated leave before benefits can be paid.

8. I have attached medical verification which confirms a serious health condition or injury indicating an anticipated absence through _____.

9. I am aware that the federal privacy standards of HIPAA (Health Insurance Portability and Accountability Act of 1996) protect the security and confidentiality of a person's health information. I have indicated in the box below my preference for confidentiality.

   ☐ **NO**, I do not want my medical leave status kept confidential. I want the University to notify other employees via email distribution, or announcement by other appropriate means, of my name and to identify me as a participant in the Donated Leave Program, so other employees may make donations of time. (I understand that my personal health information will remain confidential.)

   ☐ **YES**, I would like my medical leave status kept confidential. I do not want the University to share with other employees, via email distribution, or announcement by other appropriate means, that I am a participant in the Donated Leave Program.

_____ _____
NAME (PRINT) **SIGNATURE**

_____ _____
SOCIAL SECURITY NUMBER **DATE**

HOME PHONE NUMBER_____

PLEASE FORWARD THIS AFFIDAVIT TO HUMAN RESOURCES via fax 908-737-3319