

**STATE OF OHIO**  
**ADJUTANT GENERAL'S DEPARTMENT**  
2825 West Dublin Granville Road  
Columbus, Ohio 43235-2789

**MEMORANDUM**

**TO:** SEE DISTRIBUTION

**FROM:** Gregory L. Wayt, Major General (Ohio), The Adjutant General 

**DATE:** January 25, 2005

**SUBJECT:** POLICY – State Employee Procedure Letter #39  
Living Organ and Bone Marrow Donor Leave

**1. REFERENCES:**

Ohio Revised Code Chapter 124:139

- 2. SCOPE:** This policy applies to all full-time permanent state employees of The Adjutant General's Department. No other appointment types are eligible.
- 3. PURPOSE:** Living Organ and Bone Marrow Donor leave (donor leave) is intended to provide an opportunity for employees to receive approval for a specified amount of paid leave immediately after donating their kidney, a portion of their liver, or bone marrow in order to recuperate from the procedure.

**4. GENERAL:**

- A. Full-time employees shall receive leave with pay at their regular rate of pay during each calendar year to use during those hours when the employee is absent from work because of the employee's organ donation as follows:
- i. Up to two hundred forty (240) hours of leave for the donation of
    - a. any portion of an adult liver; or
    - b. an adult kidney
  - ii. Up to fifty-six (56) hours of leave for the donation of adult bone marrow.
- B. Donor Leave shall begin on the date of the procedure.
- C. For the duration of donor leave, employees are eligible to receive all employer-paid benefits and accrue all forms of leave.

**5. REQUEST FOR LEAVE:**

- A. Employees requesting paid Organ Donor Leave must complete the standard Request for Leave form (ADM 4258)
- i. Ten working days prior to the procedure; or
  - ii. As soon as possible after the employee is informed of the date of the procedure
- B. Employees must mark the box for "Other" and specifically indicate Liver, Kidney or Bone Marrow donation on the form.

**6. VERIFICATION OF PROCEDURE:**

- A. The employee, the employee's family member or designated representative must submit a Physician or Health Care Provider Certification form (ADM 4261) (ENCLOSURE 1) to State Human Resources

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- i. Within ten (10) days of the procedure for kidney or partial liver donation
    - ii. Within three (3) days of the procedure for bone marrow donation
  - B. Failure to submit the ADM 4261 will result in the denial of the previously submitted leave request.
- 7. WORKING DURING DONOR LEAVE:** An employee may be allowed to work a reduced schedule during any portion of the donor leave, subject to
- A. An approved medical authorization from the employee's attending physician. The physician's statement must include:
    - i. The number of hours the employee could work
    - ii. Any restrictions placed on the employee's activities.
  - B. An acceptable schedule approved by the immediate supervisor
- 8. DURATION:**
- A. Under no circumstances will donor leave be granted beyond the applicable statutory period.
  - B. Donor leave shall not be used to extend the lay-off date of employees.
- 9. DISABILITY BENEFITS:** Employees who may experience medical complications as a result of organ or bone marrow donation that extend beyond the duration of the donor leave, may apply for state disability leave benefits. Employees would be required to meet all eligibility criteria for disability leave, including serving a fourteen-day waiting period after the conclusion of donor leave.
- 10. RECOVERY OF IMPROPERLY PAID BENEFITS:** The director of Administrative Services shall initiate all necessary steps to recover donor leave benefits paid in error or paid as a result of fraud, including requesting the Attorney General to take appropriate action when necessary.

**Enclosures (1)**

**1: ADM 4261-Physician or Health Care Provider Certification form**

**DISTRIBUTION:**

**AD**

**STATE OF OHIO**  
**PHYSICIAN OR HEALTH CARE PROVIDER CERTIFICATION**  
**FOR LIVING ORGAN AND BONE MARROW DONOR LEAVE**  
(Please Print)

Employee's Name (First/Middle/Last)		Social Security Number	
_____ _____		_____	
Employee's Job Title		Agency & Employee Location	
_____		_____	
Home Address	Street	City/State	Zip
_____	_____	_____	_____
Telephone Home / Work			
( )	( )		

1. This information is being provided by:
- a) Physician  Yes  No
  - b) Practitioner  Yes  No
  - c) Another provider of health services  Yes  No.

2. Information of Physician or other health services provider who performed the procedure:

Name	Address	Street	City/State	Zip
_____	_____	_____	_____	_____

3. Date the procedure commenced: \_\_\_\_\_.

4. Where the procedure commenced:

Facility Name	Address	Street	City/State	Zip
_____	_____	_____	_____	_____

5. Type of procedure:  Kidney or Liver Donation  Bone Marrow Donation

**I certify that the information contained in this form is true to the best of my knowledge.**

\_\_\_\_\_  
Date      Attending Physician's / Health Care Provider's Signature

**I voluntarily authorize the State of Ohio to contact my Health Care Provider for clarification of the information contained in this certification. Employee's Initials:** \_\_\_\_\_

**I certify that the information contained in this form is true to the best of my knowledge and understand any misrepresentation on my part may result in denial of leave and/or discipline.**

\_\_\_\_\_  
Date      Employee's Signature