

(First Published in the Columbus Daily Advocate September 9, 2008)

ORDINANCE NO. 1249

AN ORDINANCE BY THE CITY COUNCIL OF THE CITY OF COLUMBUS, KANSAS, AMENDING ORDINANCE NUMBER 1205, AND ADDING SECTION IX-23, SHARED LEAVE, TO THE PERSONNEL REGULATIONS FOR THE EMPLOYEES OF THE CITY OF COLUMBUS.

BE IT ORDAINED BY THE GOVERNING BODY OF THE CITY OF COLUMBUS, KANSAS.

Section 1: That Ordinance 1205, and the Personnel Regulations for the Employees of the City of Columbus, Kansas, are hereby amended.

Section 2: That the following shall be a new Section IX-23 Shared Leave.

The City of Columbus has in place a shared leave program to benefit eligible employees who have exhausted all sick and vacation leave. Eligible employees who have exhausted all paid leave may apply for Shared Leave for an employee's own qualified health condition or for a family member's qualified health condition. A health condition needs to be a serious, life-threatening situation to be eligible for shared leave. An employee receiving workers compensation for the same injury/illness is not eligible for shared leave.

Eligible City employees may donate sick leave to a specific Shared Leave recipient, and the recipient can record Shared Leave and continue to receive pay instead of having to record leave without pay.

An employee is eligible to donate sick leave if he or she has a sick leave balance of at least 200 hours after donating the respective leave.

Applications Requesting Shared Leave, along with supporting documentation, and Shared Leave Donation forms shall be reviewed and processed by the City Administrator and all affected department heads on a case-by-case basis. Shared leave issues may be further addressed by the Personnel Committee when the City Administrator and/or affected department heads find that it is necessary and in the best interests of the City and the employee.

The employee requesting Shared Leave is responsible to work with his or her physician to provide complete and readable medical information in support of the request, along with the physician's certification as to the serious, life-threatening nature of the condition.

Section 3. All ordinances, resolutions or policies or parts thereof in conflict herewith are

hereby expressly repealed insofar as they conflict herewith.


Section 4. This ordinance shall take effect and be in force from and after passage and publication in the official city newspaper.

PASSED and APPROVED by the Governing Body this 2nd day of September, 2008.



HARLEY MCDANIEL, MAYOR

ATTEST:



JANICE BLANCEFT, CITY CLERK

(SEAL)



CITY OF COLUMBUS, KANSAS
SHARED LEAVE PROGRAM
CERTIFICATION OF HEALTH CARE PROVIDER

Employee Name: _____

Patient's Name: _____

Date first consulted for this condition: _____

Describe the nature of the illness, injury, impairment or physical or mental condition for which the employee is requesting shared leave from the City (please attach documentation):

Describe the diagnosis of the illness, injury, impairment or physical or mental condition (please attach documentation):

Describe the treatment and prognosis of the illness, injury, impairment or physical or mental condition (please attach documentation):

Anticipated duration the patient will be unable to work due to the condition:

From: _____ Through: _____

Dates of hospitalization, if applicable:

Date of Surgery/Surgeries, if applicable:

Physician Name: _____

Telephone Number: _____

Address:

Licensed Health Care Provider Signature:

Date:

CITY OF COLUMBUS, KANSAS
SHARED LEAVE REQUEST FORM

Employee Name: _____

Home Address: _____

Home Telephone: _____ Cell Phone: _____

Request is for: Self _____ Family Member _____

Name of Family Member and relationship, including age if child:

Date illness/injury began: _____ Anticipated duration: _____

Estimate of number of hours requested: _____

Date all paid leave will be / was exhausted: _____

Shared leave will only be granted for serious, extreme or life-threatening illnesses, injuries, impairments or physical or mental conditions.

Describe and provide any necessary information that would help in concluding that the illness, injury, impairment or physical or mental condition is serious, extreme or life-threatening:

I certify that I understand the requirements and conditions of the shared leave program. I authorize the City to obtain any necessary medical or health information regarding my request for shared leave. **I declare under penalty or perjury that the foregoing is true and correct.**

Employee Signature _____ Date _____

Approval of Shared Leave:

City Administrator

Department Head of Employee
Receiving Shared Leave

CITY OF COLUMBUS, KANSAS
SHARED LEAVE DONOR FORM

Employee Name: _____

Home Address: _____

Home Telephone: _____ Cell Phone: _____

Donations must be made in full hour increments. **The donating employee's sick leave balance must be at least 200 hours after the donation is made.**

Sick leave hours: Number of hours donated: _____

Employee receiving donated hours:

I understand that my donation is voluntary and my leave balance will be decreased by the amount contributed.

Employee Signature

Date

Approval of donation of leave:

City Administrator

Department Head of Donor Employee