APPLICATION TO RECEIVE DONATED LEAVE

Employee Name:_____ Department/Agency:_____

Please describe the catastrophic illness/injury, who is affected, and how the employee is affected:_____

_____

_____

Indicate the amount of time that will be missed because of the catastrophic illness/injury.

Number of day:_____ Beginning:_____ Ending:_____

Has the Employee filed for Family and Medical Leave? [ ] Yes [ ] No

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VERIFICATION BY ATTENDING MEDICAL DOCTOR

I certify that the above named individual has experienced a catastrophic illness and/or injury and the projected time missed is an accurate forecast of time that is needed for the condition.

Doctor's Name:_____ Date:_____

Doctor's Signature:_____

I verify that the above information is a true and accurate report of my condition as I know today. I authorize and approve distribution of this information to other Washington County employees to inform them of my condition and to permit other County employees to donate sick leave to me. I understand and agree that my Appointing Authority and/or the County Commissioners will make notice of my need for leave and that I should take no other action to solicit or request donation of leave from other staff. I have read, understand, and agree with the limitations of this program as outlined in the Sick Leave Donation Policy. I understand and agree that any leave taken under this program will be included and is subject to the twelve (12) week limits of the Family and Medical Leave Act. I understand and agree that any employee donating leave to me will have his or her identify kept confidential from me.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

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This application has been reviewed and APPROVED/DENIED. (Circle One)

Signature of Reviewer

Date

Printed Name of Reviewer