APPLICATION TO DONATE SICK LEAVE

Donator's (Transferor) Name:_____ Dept./Agency:_____

Receiver's (Transferee) Name:_____ Dept./Agency:_____

Please check one of the responses below:

___ I am responding to a notice that an employee is in critical need of sick leave.

___ I am aware of this employee's need and I am making this offer.

If the second response is marked, I understand that the Receiver indicated must be contacted by his Appointing Authority to determine if the Receiver is eligible and willing to accept the leave. The Receiver will be required to complete an Application to Receive Donated Sick Leave prior to determination of eligibility.

Hours of Sick Leave to be donated must be in one (1) day increments up to a maximum of ten (10) days (80 hours) equivalence:_____

Balance of Sick Leave after donation:_____

I hereby certify that his request is made voluntarily. I was not coerced, intimidated, or financially induced into donating leave. By signing, I hereby relinquish all right to the leave shown above and the benefits accrued to or attached to the same. I understand and agree that the donation of the leave is irrevocable and that no leave actually donated will be refunded to me. I certify that I will have eighty (80) hours of sick leave after making this donation.

_____ _____
Transferor's (Donator's) Signature Date

_____ _____
Witness's Signature Date

CERTIFICATION

___ Sick Leave Balance above is certified and correct.
___ Sick Leave Balance above is certified as not correct.
___ Balance of Sick Leave

_____ _____
Signature of Appointing Authority or Designee Date

_____ _____
Printed Name Title

Sick Leave Donation: [ ]APPROVED [ ]DENIED

_____ _____
Signature of Appointing Authority Date