

Application to Donate Sick Time Leave

Donator's Name: _____ Office/Department: _____

Employers Name to Receive Leave: _____

Hours of Sick Leave to be donated: _____

Balance of Donator's Sick Leave after donations: _____

I hereby certify that this request is made voluntarily. I was not coerced, intimidated or financially induced into donating leave. By signing, I hereby relinquish all rights to the leave shown above and the benefits accrued to or attached to the same. I understand that the donation of the leave is irrevocable and that no leave will be refunded to me in cash or kind.

Donator's Signature

Date

Certification

_____ Sick Leave Balance above is certified as correct
_____ Sick Leave Balance above is certified as not correct
_____ Balance of Sick Leave

Certified By: _____
Signature of Certifying Party

Date

Printed Name

Position Title

Sick Leave Donation Approved Not Approved *(Circle One)*

Certified By: _____
Elected Official/Department Head

Date