APPLICATION FOR SICK LEAVE SHARING

☐ ORIGINAL REQUEST
☐ AMENDED REQUEST

Name of Recipient: _____

Department: _____

Social Security Number _____

Amount of Sick Leave Needed _____

Please provide a reason transferred leave is needed, including a brief description of the nature, severity, and anticipated duration of the medical emergency. (If this an amended request, provide reason for extension)

_____

_____

_____

_____

Please attach certification by one or more physician(s) of the medical reason that the employee will be unable to perform the duties and responsibilities of his/her position, or the reason for the extension, if an amended request.

_____

Signature of Recipient or Representative Date

The above named employee has been approved to receive donated sick leave in accordance with the provisions of the Sick Leave Sharing Policy.

_____

Signature of Payroll Department Date

Original Date: Aug-08