SICK LEAVE DONATION REQUEST FORM

Recipient's Information

Date of Application: _____

Recipient Employee's Name: _____

Employee ID No.: _____

Address: _____

City, State, Zip Code: _____

Job Position: _____

Department / School: _____

Date of Hire: _____

Request to participate due to the following:

_____

_____

Please read the information below:

- Medical documentation from a physician **MUST** be submitted **BEFORE** the request can be processed.
- The recipient must be absent for 20 consecutive days to receive donated days.
- The recipient is limited to 20 days donated per one full school year and 60 days lifetime.
- The recipient must be employed at least one full school year.
- Completion of this form does not guarantee sick leave donations; it simply establishes that an individual is willing and eligible to receive donated leave.

RETURN THIS COMPLETED FORM TO THE CENTRAL OFFICE, HUMAN RESOURCES DEPT, SUITE 208

By my signature below, I certify that I have read the Richmond County Board of Education's Sick Leave Bank Policy and abide by its terms and conditions. Furthermore, I understand that Sick Leave is donated on a voluntary individual basis by eligible donors.

_____

Employee Signature *Date*

Departmental Use Only

In accordance with the Sick Leave Bank Policy, your request to donate is :

☐ Approved ☐ Denied Reason:_____

Classification Status: ☐ Certified ☐ Classified **Date Approved**: _____

Doctor's Statement: ☐ Yes ☐ No **Number of Days Approved:** _____

_____

Benefits Coordinator Signature *Date*

_____

Director of Human Resources Signature *Date*

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