

Voluntary Sick Leave Donation Program

DONEE Leave Request Form

Employee Name

Job Title:

Department:

Supervisors Name:

Supervisor's contact #:

Best Contact #

Email address:

Emergency contact name:

Emergency contact phone number:

REQUEST

According to the provisions of the Leave Donation Policy, I, _____, indicate my willingness to accept donated sick leave. My signature below certifies that:

1. I have a documented medical condition that warrants absence from work for an extended period . *A copy of my Request for Leave of Absence form and FMLA Certification or Physician Certification form is attached.*
2. I realize that I cannot utilize donated leave time until all of my own accumulated sick, vacation, personal, or compensatory leave accruals have been exhausted at or below 40 combined hours.
3. I understand that my name will appear on the City's list of employees in need of donated leave.
4. I am not receiving nor have I applied for lost wage benefits under Worker's Compensation.
5. I understand that I will accrue vacation and sick leave while utilizing donated sick leave and that those hours shall be applied before donated time so that my balance will not exceed an accumulation of forty (40) total hours of vacation and personal time.

Submit original signed and completed form to the Human Resources Director

Employee signature

Date

Verification of Eligibility:

FOR HR USE ONLY

Full time or permanent part time employee

Completed Probationary Period

Not receiving Worker's Compensation benefits

Meets requirement of a "Sick Leave Use"

Completed FMLA Serious Health Condition for Employee or Family Member or Physician Certification form for non-FML requests

Has exhausted all but forty (40) hours of his/her combined accrued sick and vacation time

Employee's last day worked

Approver's Name

Title

Date