CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION

DONATING EMPLOYEE INFORMATION

1. Employee Name:_____ 2. SSN:_____

3. Employee Address:_____

4. Employee Telephone:_____ 5. Employer Telephone:_____

BENEFICIARY EMPLOYEE INFORMATION

6. Receiving Employee Name:_____ 7.SSN:_____

8. Beneficiary's Employer:_____

DAYS TO BE DONATED TO BENEFICIARY (NOT TO EXCEED 30 DAYS)

9. Number of Days to be Donated:_____

CERTIFICATION OF DONATING EMPLOYEE

I certify that I hereby donate the above number of my sick leave days to the beneficiary employee listed above. My employer has my permission to transfer the indicated number of sick leave days to the employer of the beneficiary for his or her use due to a catastrophic illness/injury as defined by Act 93-753. It is my understanding that my sick leave balance will be reduced by the specified number of days hereon and that the donated days will not be returned to me.

Donating employee's signature:_____Date:_____

Witness:_____Date:_____

CERTIFICATION OF DONATING EMPLOYER

11. I hereby certify that the donating employee's information listed above is correct to the best of my knowledge.

Authorized Signature:_____Date:_____

Title:_____

RECEIPT OF BENEFICIARY EMPLOYER

12. The above noted number of sick leave days have been credited to the sick leave account of the beneficiary employee.

Authorized Signature:_____Date:_____

Title:_____

INSTRUCTIONS FOR CATASTROPHIC SICK LEAVE FORM

1. The DONATING EMPLOYEE originates the form and completes items 1 through 10 and gives to his/her employer.

2. It is suggested that the DONATING EMPLOYER contact the BENEFICIARY EMPLOYER by telephone to verify that:
    a. beneficiary employer has a sick leave bank
    b. beneficiary employer has on file a certified statement from a licensed physician stating that the beneficiary employee has a catastrophic illness.

3. The DONATING EMPLOYER completes item 11 and forwards a copy to BENEFICIARY EMPLOYER.

4. The BENEFICIARY EMPLOYER completes item 12 and forwards a copy to:
    a. donating employee
    b. beneficiary employee
    c. donating employer

CATASTROPHIC SICK LEAVE FORM

ATTENDING PHYSICIAN STATEMENT
ALEXANDER CITY SCHOOL SYSTEM
ALEXANDER CITY, ALABAMA

Section 16-22-9, The Code of Alabama gives the Alexander City Board of Education the authority to maintain a sick leave bank for its employees. It also establishes provisions for "catastrophic sick leave" which is defined in Section 1. (a) (3) as follows:

"Any illness, injury, or pregnancy or medical condition related to childbirth certified by a licensed physician which causes the employee to be absent from work for an extended period of time."

Please complete the following information:

Employee's Name_____ SSN:_____
Name of injured/ill person (if other than employee):_____
_____

Description of current injury/illness:_____
_____
_____
_____

Physician's recommendation:_____
_____
_____

Date individual first seen by physician for this injury/illness:_____

Estimated length of absence from work in days:_____

I certify that the information above concerning the named employee of the Alexander City Board of Education is correct and that the related injury/illness meets the criteria of catastrophic sick leave as defined above and interpreted by me.

Please type or print physician's name and address:

_____ **_____**
_____ **Signature of Attending Physician**
_____