CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION

EMPLOYEE WHO IS GIVING DAYS TO PERSON NAMED IN NUMBER 2 BELOW

1. Employee Name: _____
   Employee Number:_____
   Employee Address: _____
   Employee Telephone(s): _____
   Employer: _____ School/Dept: _____

   DAYS TO BE GIVEN TO RECEIVING EMPLOYEE NAMED IN NUMBER 2 (not to exceed 30 days) Please spell AND write number of WHOLE days to be donated: _____ /_____

   I certify that I hereby donate the above number of my sick leave days to the beneficiary employee listed below. My employer has my permission to transfer the indicated number of sick leave days to the employer of the beneficiary for his/her use due to a catastrophic illness/injury as defined by Act 93-753. I understand 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, unless not used.
   Donating Employee's Signature (Required): _____ Date: _____
   Witness (Required): _____ Date: _____

EMPLOYEE WHO IS RECEIVING DAYS FROM PERSON NAMED IN NUMBER 1 ABOVE

2. Receiving Employee Name: _____
   Employee Number_____
   Employer: _____ School/Dept: _____

EMPLOYER OF DONATING EMPLOYEE - CERTIFICATION (ADMINISTRATOR/PAYROLL)

3. I hereby certify that the donating employee's information listed in numbers 1 above is correct to the best of my knowledge.
Authorized Signature: _____ Date: _____
Title: _____

EMPLOYER OF RECEIVING EMPLOYEE - RECEIPT OF DONATION (ADMINISTRATOR/PAYROLL)

4. The above noted number of sick leave days have been credited to the sick leave account of the beneficiary employee. (Please give a copy of this form to the beneficiary employee.)
Authorized Signature: _____ Date: _____
Title: _____

INSTRUCTIONS FOR COMPLETING FORM:

1. The **DONATING EMPLOYEE** originates the form and completes items 1 and 2 and gives to his/her employer.
2. It is suggested that the donating employer contact the beneficiary employer by telephone to verify the following:
   a. beneficiary employer has a sick leave bank
   b. beneficiary employer has on file a certified statement from the licensed physician stating that the beneficiary employee has a catastrophic illness/injury.
3. The **DONATING EMPLOYER** completes **Item 3** and forwards to **BENEFICIARY EMPLOYER**.
4. The **BENEFICIARY EMPLOYER** completes **Item 4** and forwards a copy to the following:
   a. donating employee
   b. beneficiary employee
   c. donating employer

----------PLEASE RETURN VIA FAX, EMAIL OR MAIL TO:----------

Fax: (251) 221-6237, MCPSS-Human Resources, Employee Relations, P. O. Box 180069, Mobile, AL 36618
(Employee Last Name A-L or Central Office) Mia Ward: imward@mcpss.com, (251) 221-4542
(Employee Last Name M-Z or Transportation) Angel Young: ahyoung@mcpss.com, (251) 221-4528