<u>Request to Receive Donated Sick Leave</u>

AN EMPLOYEE REQUESTING TO RECEIVE DONATED SICK LEAVE MUST MEET ALL OF THE ELIGIBILITY CRITERIA LISTED BELOW AND MUST FILE THIS FORM WITH THE SUPERINTENDENT/DESIGNEE.

Name of Receiving Employee: ____

School: ____

Social Security Number: ____

ELIGIBILITY CRITERIA TO BE VERIFIED BY SUPERINTENDENT/DESIGNEE

- ☐ The receiving employee suffers from a catastrophic loss to his/her personal or real property, due to a natural disaster or fire, that either has caused or will likely cause the employee to be absent for at least ten (10) consecutive working days; and/or
- ☐ The employee or a member of his/her immediate family suffers from a medically certified illness, injury, impairment, or physical or mental condition that has caused or is likely to cause the employee to be absent for at least ten (10) days.
- ☐ The employee has completed and returned the “Request to Receive Donated Sick Leave” form and, when the reason can be certified medically, attached to this form a statement from a licensed physician the need for the absence and use of leave.
- ☐ The employee has exhausted his/her accumulated sick leave, personal leave, emergency leave, and any other paid leave granted by the Board.
- ☐ The employee has complied with the District’s policies governing the use of sick leave.

I hereby give my permission to the Superintendent/designee to notify District employees of my need for the use of donated sick leave days, including a general description of the reason for the need.

______________________________________ ____________________

Employee’s Signature ***Date***

I certify that the above-mentioned criteria have been met by this employee and that his/her name and a general description of the reason for need will be given to supervising administrators for circulation to District employees.

______________________________________ ____________________

Superintendent/HR Designee’s Signature ***Date***