

CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION

Donating Employee Information

Employee Name:

Social Security Number:

Employee No:

Employee Address:

Employee Telephone(s):

Employer: Enterprise City Schools

School:

Beneficiary Employee Information

Beneficiary Employee Name:

Social Security Number:

Beneficiary's Employer/School:

Days to be Donated to Beneficiary (not to exceed 30 days)

Number of days to be donated:

Certification of Donating Employee

I certify that I hereby donate the above noted 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 99-581. It is my understanding that my sick leave balance will be reduced by the specified number of days and that the donated days will not be returned to me unless the beneficiary does not use them.

 Donating employee's signature

 Date

FOR PAYROLL OFFICE USE ONLY

Certification of Donating Employee

I certify that the donating employee's information listed above is correct to the best of my knowledge and I have taken the designated number of days from the donating employee's sick leave balance.

Authorized Signature _____

 Title

 Date

Receipt of Beneficiary Employer

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

Authorized Signature _____

 Title

 Date