

REQUEST FOR SICK LEAVE DONATIONS

NAME: _____

DATE HIRED BY CITY: _____

DEPARTMENT: _____

POSITION: _____

WHY DO YOU NEED DONATED SICK LEAVE? _____

HOW MANY HOURS ARE NEEDED (IF KNOWN)? _____

IS COPY OF PHYSICIAN'S FMLA CERTIFICATION ATTACHED (Required)? YES NO

ARE YOU GOING TO RECEIVE ANY BENEFIT OR FINANCIAL REIMBURSEMENT AS A RESULT OF YOUR ABSENCE FROM CITY EMPLOYMENT? YES NO IF YES, WHAT BENEFIT AND HOW MUCH? _____

WHAT HAS HAPPENED TO YOUR OTHER LEAVE ACCRUALS (sick, vacation, holiday, comp time, etc.)? _____

WAIVER: *By signing and submitting this form, I am authorizing the Donation Committee to review and consider any and all information I have submitted in approving or denying my request. I further authorize the City to release to the Committee, any charts or summaries created by the City showing the use of my leave accruals. Upon approval of my request by the Committee, I am authorizing the Committee and the City to release any and all information on this form and the leave accrual/use charts and summaries prepared by the City to any City employee who may request it while considering donating time to me.*

SIGNED: _____ DATE SUBMITTED: _____

DONATION COMMITTEE ACTION:

Approved

Denied

Committee Vote:

By: _____

Date: _____