REQUEST FOR LEAVE DONATIONS

Employee ID:_____

Last Name (please print)	First	Initial

Home Address	Street	Apt. #

City	State	Zip Code

Work Location/Facility: _____

I request solicitation of donated leave from other employees within this agency for my use as sick leave for the following reason:

_____ My personal illness, disability, dental or medical care **or**,

_____ Care of Family Member-Name/Relationship: _____

_____

A completed Solicitation Request and a Health Care Provider Certification form must be attached.

ACKNOWLEDGEMENT

As evidenced by my signature below, I certify that I am fully aware of the requirements for eligibility to solicit and use donated leave and that I am not receiving any other disability benefits from any source (such as Social Security, Workers' Compensation or Short-Term Disability insurance). If, in the future, I am the recipient of any of these benefits, I understand that I must immediately notify my Appointing Authority.

_____ _____
Employee or Designee's Signature Date

Designee's Relationship _____ Phone #_____

Reviewed & Eligibility Verified by: _____
Signature of HR Representative/Date

APPROVED _____ DENIED* _____

_____ _____
Signature of Appointing Authority or Designee Date

Print Name: _____

***Note to Appointing Authorities: Before the final decision is made to deny a request, you must personally contact the Department Human Resources Director.**

Retention Schedule: Upon completion, this form shall be retained permanently in the Recipient's Leave Donation File in Correctional Human Resources Management and in the local Medical File.