APPENDIX H

The School District of Escambia County
75 North Pace Blvd.
Pensacola, FL 32505
Fax 850-469-6180

Sick Leave Donation

EMPLOYEE / FAMILY SICK LEAVE TRANSFER APPLICATION

DONOR INFORMATION

Name: ________________________________ Social Security (last 4 digits): _____________________

Job Title: _____________________________ Work Location: ________________________________

Sick Leave to be donated (days) ___________________________ (hours) ____________________________

Family Member _______________________ or Employee _____________________________

RECIPIENT INFORMATION

Name: ________________________________ Social Security (last 4 digits): _____________________

Job Title: ______________________________ Work Location: ________________________________

The employee donating the days must have a balance of 10 days of accrued sick leave after the donation of the sick leave day(s). The employee making the donation must fill out the initial paperwork requesting to make a donation to the employee in need and turn in that paperwork to the Human Resource Services Department.

The donation of leave will be distributed in chronological order according to the date the donation request was processed. If an employee returns to work before the donated days are exhausted/spent, then the unused leave will be returned to the donating employee.

Donated leave must be submitted within 90 days of recorded illness.

I have read and understand the requirements of the Employee / Family Sick Leave Transfer Policy and am under no duress, obligation, coercion, or the like, to donate my sick leave to the above named recipient. I further understand that my donation of sick leave is irrevocable upon donation and thereby waive any entitlement to future payment or credit of said donated sick leave.

_______________________________________ ________________ ________________________________
Donor's Signature Date Time

_______________________________________ ________________ ________________________________
Human Resources Authorization Date processed Dates authorized absent

_______________________________________ ________________ ________________________________
Payroll Authorization Date processed Dates sick leave transferred

INCOMPLETE FORMS WILL NOT BE PROCESSED

APPENDIX I

The School District of Escambia County
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Sick Leave Donation
Physician's Statement

Authorization for release of Medical Information

I authorize my physician to release any information recorded on the examination report and any other pertinent facts and documents concerning my condition to the School District of Escambia County.

_______________________________________ ________________________
Applicant Signature Date

To be completed by the attending physician:

Employee Name: ____

This is to certify that the above named employee is unable to report for duty beginning ______________ due to:

<u>Explanation of medical condition</u>

_____ Illness ____

_____ Injury _____Job Injury ____
____

_____ Surgery Date of Surgery ________________ Explanation of Surgery ________________
____
____

_____ Therapy or Specialized Treatments
Explanation of Therapy or Specialized Treatments
____
____

Return to duty date __________________

The patient is responsible for the completion of this form without expense to the School District of Escambia County. Please provide any additional information and copies of your office notes, if you feel they are pertinent to an understanding of the patient's condition.

License Number ________________ Date ______________ Phone Number _________________

Physician's Name____

Address____

Physician's Signature____