	Request to Donate Sick Leave Days	Received Date:_____ Time:_____

Employee Donor's Information

Donors' Name:	Date:	Cost Center:
Employee ID #:	Work Telephone Number: ( )	

I authorize my employer to transfer _____ days of sick leave to the following recipient (minimum one day).

I certify I have read and understand the requirements of 1001.41; 1012.22; 1012.23, F.S., – Sick Leave Transfer Plan policy and that I am eligible (maintaining a minimum of 10 days of sick leave) and willing to donate my personal sick leave days as specified below. I further understand that the donated sick leave hours will be ***permanently*** *deducted from my sick leave balance at the end of the pay period unless not used by the recipient. I further understand that my donation of sick leave will not be shared with recipient*

Donating Employee's Signature: _____

Recipient's Information

Recipient's Name:	Employee ID #:
Cost Center:	

The following is completed by Human Resources

Donor			**Recipient**	
Date:				
From: Sick Leave Transfer Plan Administrator Director of Administrative Services 652 Third Street Chipley, FL 32428 Telephone 850/638-6222 FAX 850/638-6226			# Days Credited:	PPE Date:
			# Days Credited:	PPE Date:
			# Days Credited:	PPE Date:
			# Days Credited:	PPE Date:
Verified # of Days available for Donation _____			# Days Credited:	PPE Date:
# Days Donated:	PPE Date:		# Days Credited:	PPE Date:
☐ Approved Per Criteria	☐	Disapproved Per Criteria	# Days Credited:	PPE Date:
Print SLTP Administrator's Name:			# Days Credited:	PPE Date:
SLTP Administrator's Signature:				
Comments:			Comments:	

SLDP-0100-2013 – Request to Donate Sick Leave Days 10/13

Request to use Donated Sick Leave Days Individual

To: Sick Leave Donation Program Administrator
652 Third Street
Chipley, FL 32428

Date Requested: _____

Requester/ Employee
Recipient's Name: _____ ID #: _____
Cost Center: _____
Date absence began or will begin: _____ Through (if known): _____
Home/Cell
Print Representative's Name (if applicable): _____ Telephone #: _____

Representative's Signature: _____

___*I certify I have suffered an illness, accident or injury and have used all my personal leave hours. I am requesting to use donated sick leave hours to cover my absence due to my current personal illness, accident or injury.*

I authorize WCSD to use my name and release a general description of the medical circumstances in order to determine my eligibility in accessing this benefit.

Home/Cell
Requester's Signature: _____ Telephone #: _____

Medical Certification - CONFIDENTIAL

***To Medical Practitioner:** Based on my current illness, accident or injury, I am applying for donated sick leave hours. Since you examined me during my current illness, accident or injury, I am requesting you to complete the following information and answer any relevant questions asked by WCSD's Sick Leave Transfer Plan Administrator to determine my eligibility for this benefit.*

***Employee:** Check one: Please return this form to ☐ me, or ☐ the designated representative listed above.*

Date Requested: _____ Requester's signature: _____

*******THE FOLLOWING IS CONFIDENTIAL MEDICAL INFORMATION******* **PLEASE PRINT**

Business
Print Medical Practitioner's Name: _____ Telephone: _____
Mailing Address: _____
License #: _____ State Issued: _____ Date of Issue: _____
Patient Name: _____

Brief explanation of medical condition: _____

Date patient (above requester) was first examined for current condition: _____
Date patient is expected to recover or be released to duty: _____ Check one: ☐ Partial ☐ Full
Patient may return to work on: _____ with the following restrictions:

Medical Practitioner's Signature: _____ Date: _____

SLDP-0101-2013 – Request to Use Donated Sick Leave Days 10/13

Request to use Donated Sick Leave Days Caregiver

To: Sick Leave Donation Program Administrator
652 Third Street
Chipley, FL 32428

Date Requested: _____

Requester/
Recipient's Name: _____ Employee ID #: _____

Cost Center: _____

Date absence began or will begin: _____ Through (if known): _____

I certify I am a caregiver of _____ who is my (please mark one) father, mother, brother, sister, husband, wife, child, or other close relative, or member of my own household* who has suffered a documented illness, injury, or accident, requiring treatment by a physician, which requires the need for a caregiver.*

**State relationship_____*

I authorize WCSD to use my name in my request for a need for caregiving services.

Requester's Signature: _____ Telephone #: Home/Cell _____

Medical Certification - CONFIDENTIAL

To Medical Practitioner: Based on my current need for a caregiver, since you examined me during my current illness, accident or injury, I am requesting you to complete the following information and answer any relevant questions asked by WCSD's Sick Leave Transfer Plan Administrator.

Date Requested: _____ Requester's signature: _____

*******THE FOLLOWING IS CONFIDENTIAL MEDICAL INFORMATION******* **PLEASE PRINT**

Print Medical Practitioner's Name: _____ Business Telephone: _____
Mailing Address: _____
License #: _____ State Issued: _____ Date of Issue: _____
Patient Name: _____

Brief explanation of medical condition: _____
_____

Date patient was first examined for current condition: _____
Estimated time that the patient needs a caregiver:
Beginning _____ Ending_____

Medical Practitioner's Signature: _____ Date: _____

SLDP-0102-2013 – Request to Use Donated Sick Leave Days 10/13