SICK LEAVE DONATION PROGRAM 6.916+

PURPOSE

To allow an employee of the Washington County School District to donate sick leave to other employees within the Washington County School District.

GUIDELINES

1. Transferring sick leave days is a manual process performed by payroll personnel.

2. Donating employees must meet the following eligibility requirements:
   - maintain a minimum of 10 days of sick leave after a donation,
   - make a donation of at least one (1) day, and
   - provide a completed "SLDP-0100-2013 - Request to Donate Sick Leave" form to Director of Administrative Services.

3. Donation of sick leave can be requested by an employee:
   - who has a documented illness, accident or injury which requires (as certified by the treating physician) absence from the workplace for a minimum of ten (10) consecutive work days, (could include the required three (3) days without pay).

     or

   - whose father, mother, brother, sister, husband, wife, child, or other close relative, or member of his/her own household must have suffered a documented illness, injury, or accident, requiring treatment by a physician, which requires the absence of the employee from the workplace for a minimum of ten (10) consecutive work days (could include the required three (3) days without pay).
   - who has been absent for three (3) continuous work days without pay, due to this illness
   - is not eligible for Worker Compensation benefits
   - who has provided a completed:
     "SLDP-0101-2013 – Request to Use Donated Sick Leave (Individual)" form

     OR

     "SLDP-0102-2013 – Request to Use Donated Sick Leave (Caregiver)" form

     to Director of Administrative Services; within 30 days of the 1st day of Leave Without Pay, completion of the form requires:
     a. the bottom portion of form is to be completed and signed by his/her attending physician,
     b. a new medical certification form if the request to use donated sick leave days is beyond the physician's "return to work date" on the original medical certification form.

- authorize the release of their name and acknowledge eligibility in making known to WCSD employees your request for donated Sick Leave days

4. All requested and/or donated sick leave will be confined to that fiscal year. If there is a continued need past the end of the fiscal year, a new request must be submitted and requirements met again.

5. Director of Administrative Services receives the request to donate or use sick leave days' form and refers the request to the Sick Leave Donation Committee.

6. The Sick Leave Donation Committee:
   - reviews the request to ensure all requirements are met as per the required criteria,
   - notifies requesting employee whether or not a request is approved and provides an explanation why the request was denied, if denied,
   - communicates with Washington County School District employees when a Request to Use Donated Sick Leave days is approved via mass email.
   - Payroll personnel tracks donated and used sick leave on the "Sick Leave Log",

7. Director of Administrative Services or designee will time and date stamp donation forms in the order received then logs donations in the order they are received and Payroll credits them to the receiving employee on a first in, first out basis.

8. Payroll credits employees receiving donated sick leave with the number of days or hours needed to bring them up to the number of required days for the pay period.

9. All unused donated sick leave days are returned to the donors in a last in, first returned order.

ASSOCIATED FORMS
SLDP-0100-2013 – Request to Donate Sick Leave days
SLDP-0101-2013 – Request to Use Donated Sick Leave days (Individual)
SLDP-0102-2013 – Request to Use Donated Sick Leave days (Caregiver)

ADOPTED DATE: 12/09/2013

REVISION DATE(S): 06/30/2014; 10/14/2019; 08/10/2020

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

Cost Center: _____

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

Print Representative's Name (if applicable): _____ Home/Cell 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.

Requester's Signature: _____ Home/Cell 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**

Print Medical Practitioner's Name: _____ Business 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