Formatted: Centered

Request to Donate Sick Leave

AN EMPLOYEE WISHING TO DONATE SICK LEAVE DAYS TO ANOTHER DISTRICT EMPLOYEE SHALL COMPLETE THE TOP PORTION OF THIS FORM AND SUBMIT IT TO THE CENTRAL OFFICE. THE RECEIVING EMPLOYEE SHALL BE RESPONSIBLE FOR PROVIDING ANY REQUIRED STATEMENT OF NEED CERTIFIED BY A LICENSED PHYSICIAN.

EMPLOYEES SHALL NOT SOLICIT SICK LEAVE DAY DONATIONS FROM OTHER EMPLOYEES.

Formatted: ksba normal

Formatted: sideheading, Left

NAME: _____ **SCHOOL/WORK SITE:** _____

EMPLOYEE IDENTIFICATION NUMBER: _____

NUMBER OF SICK LEAVE DAYS I WISH TO DONATE: _____

NOTE: *The number donated may not reduce the employee's accumulated sick leave balance to less than fifteen (15) days.*

DISTRICT EMPLOYEE TO WHOM I WISH TO DONATE DAYS: _____

_____ _____

Employee's Signature ***Date***

TO BE COMPLETED BY CENTRAL OFFICE DESIGNEE

The employee to whom sick leave days are to be donated ☐ is eligible ☐ is not eligible to receive the days based on the following criteria.

Check each requirement below that is met:

- ☐ The donating employee's sick leave balance will not fall below fifteen (15) days.
- ☐ The receiving employee suffers from a catastrophic loss to his/her personal or real property, due to either a natural disaster or fire, that either has caused or will likely cause the employee to be absent for at least ten (10) consecutive working days; and/or
- ☐ The receiving employee or a member of his/her immediate family suffers from a medically certified illness, injury, impairment, or physical or mental condition that has caused or is likely to cause the employee to be absent for at least ten (10) days.
- ☐ As appropriate, the receiving employee's need for the absence and use of sick leave are certified by a licensed physician (as attached).
- ☐ The receiving employee has exhausted his/her accumulated sick leave and any other paid leave granted by the Board.
- ☐ The receiving employee has complied with the District's policies governing the use of sick leave.

_____ _____

Signature of Superintendent/designee ***Date***

Request to Donate Sick Leave

AN EMPLOYEE WISHING TO DONATE SICK LEAVE DAYS TO THE SICK LEAVE BANK ~~ANOTHER DISTRICT EMPLOYEE~~ SHALL COMPLETE THE TOP PORTION OF THIS FORM AND SUBMIT IT TO THE CENTRAL OFFICE. ~~THE RECEIVING EMPLOYEE SHALL BE RESPONSIBLE FOR PROVIDING ANY REQUIRED STATEMENT OF NEED CERTIFIED BY A LICENSED PHYSICIAN.~~

NAME: _____ **SCHOOL/WORK SITE:** _____

EMPLOYEE IDENTIFICATION NUMBER: _____

NUMBER OF SICK LEAVE DAYS I WISH TO DONATE: _____

NOTE: *The number donated may not reduce the employee's accumulated sick leave balance to less than fifteen (09) ~~(15)~~ days.*

~~**DISTRICT EMPLOYEE TO WHOM I WISH TO DONATE DAYS:**~~ _____

_____ _____

Employee's Signature ***Date***

TO BE COMPLETED BY CENTRAL OFFICE DESIGNEE

The employee to whom sick leave days are to be donated ☐ is eligible ☐ is not eligible to receive the days based on the following criteria.

Check each requirement below that is met:

- ☐ The donating employee's sick leave balance will not fall below nine (09)~~fifteen (15) days.~~
- ☐ The receiving employee suffers from a catastrophic loss to his/her personal or real property, due to either a natural disaster or fire, that either has caused or will likely cause the employee to be absent for at least ten (10) consecutive working days; and/or
- ☐ The receiving employee or a member of his/her immediate family suffers from a medically certified illness, injury, impairment, or physical or mental condition that has caused or is likely to cause the employee to be absent for at least ten (10) days.
- ☐ As appropriate, the receiving employee's need for the absence and use of sick leave are certified by a licensed physician (as attached).
- ☐ The receiving employee has exhausted his/her accumulated sick leave and any other paid leave, and extended employment days granted by the Board.
- ☐ The receiving employee has complied with the District's policies governing the use of sick leave.

_____ _____

Signature of Superintendent/designee ***Date***

Review/Revised:9/13/10

PERSONNEL 03.12321 AP.21

Sick Leave Bank Deposit Authorization

NAME: _____

TITLE: _____

SCHOOL/LOCATION: _____

EMPLOYEE IDENTIFICATION NUMBER: _____

I do hereby voluntarily agree to contribute one (1) of my accumulated sick leave days to the Sick Leave Bank. I understand that this will qualify me to apply for using days from the Sick Leave Bank according to approved procedures. I understand that my accumulated sick leave account will be reduced by one (1) day for each day that I am required to contribute to participate as a member in the Sick Leave Bank and that I must apply to the Sick Leave Bank Usage Approval Committee to use days from the Sick Leave Bank. I understand that I still must submit the regular sick leave cards through normal channels required by the school system.

If requested, I agree to submit a completed medical certification form to the Sick Leave Bank Usage Approval Committee for verification of medical condition. I further agree that the decision of the Usage Approval Committee shall be final.

If you wish to voluntarily participate in the Sick Leave Bank, complete and return this form to the Superintendent/designee by the date specified by the Site Administrator. Employees who are hired after that date who wish to participate in the Sick Leave Bank must return this completed form to the Superintendent/designee within ten (10) working days of employment.

_____ _____

Employee's Signature ***Date***

Sick Leave Bank Usage Application

NAME: _____

TITLE: _____

SCHOOL/LOCATION: _____

EMPLOYEE IDENTIFICATION NUMBER: _____

NUMBER OF DAYS REQUESTED: _____

REASON FOR REQUEST:

☐ Serious accident by the employee requiring extended work absences;

☐ Serious illness of the employee;

☐ Extended hospitalization of the employee; or

☐ Other serious, extenuating circumstances normally allowed for sick leave approved by the Sick Leave Bank Committee.

STARTING DATE OF LEAVE: _____ **ENDING DATE OF LEAVE:** _____

NATURE OF ILLNESS OR INJURY: Please provide specific information for which the sick leave is requested.

_____

_____

_____

_____

If requested, you must attach a detailed statement from your attending physician stating the nature of the illness and the date that your physician anticipates releasing you to return to work. If this request is due to an illness of a family member, please provide the same documentation.

DECISION OF SICK LEAVE BANK USAGE COMMITTEE

☐ **APPROVED** **NUMBER OF DAYS:** _____ **BEGINNING DATE:** _____

☐ **DENIED** **REASON:** _____

_____ _____

Signature, Committee Chairperson ***Date***

Sick Bank members may appeal the Committee's decision. (See 03.16 AP.1 and 03.16 AP.2.)