Request to Receive Donated Sick Leave

AN EMPLOYEE REQUESTING TO RECEIVE DONATED SICK LEAVE MUST MEET ALL OF THE ELIGIBILITY CRITERIA LISTED BELOW AND MUST FILE THIS FORM WITH THE SUPERINTENDENT/DESIGNEE.

Name of Receiving Employee _____

School/Work Site _____

Social Security/Employee Identification Number _____

ELIGIBILITY CRITERIA TO BE VERIFIED BY SUPERINTENDENT/DESIGNEE

☐ 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 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) CONSECUTIVE WORKING days.

☐ The employee has completed and returned the "Request to Receive Donated Sick Leave" form and, when the reason can be certified medically, attached to this form a statement from a licensed physician certifying the need for the absence and use of leave.

☐ The employee has exhausted his/her accumulated sick leave and any other paid leave granted by the Board.

☐ The employee has complied with the District's policies governing the use of sick leave.

I hereby give my permission to the Superintendent/designee to notify District employees of my need for the use of donated sick leave days, including a general description of the reason for the need.

_____ _____

Employee's Signature ***Date***

I certify that the above-mentioned criteria have been met by this employee and that his/her name and a general description of the reason for need will be given to supervising administrators for circulation to District employees.

_____ _____

Superintendent/designee's Signature ***Date***

TO BE COMPLETED BY SUPERINTENDENT/DESIGNEE

Leave shall be granted as follows:

☐ Entire/successive days

☐ Partial/successive days

☐ Intermittent leave

☐ Entire days, intermittent leave

☐ Partial days, intermittent leave

☐ Other (explain) _____

Review/Revised:3/13/2006

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 WITHIN TEN (10) WORKING DAYS. 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 (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) CONSECUTIVE WORKING 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***

Review/Revised:5/11/2015

Verification of Employment

Date: _____

*The following individual, who has applied for employment in the **Todd County** School District, has reported that s/he was formerly employed by your school district/agency:*

_____ _____

Name of Former Employee ***Social Security #***

We request that you verify years of experience and provide other information as noted below. Please return this form to Todd County School's Personnel Department.

_____

Signature of Person Requesting Information

_____

Position/Title

This is to certify that the employee listed above was employed by:

☐ _____ Schools

☐ _____ College/University

☐ Kentucky Department of Education, Department of _____

☐ Other; please specify: _____

Beginning Date (Month/Day/Year)	Ending Date (Month/Day/Year)	No. of days in School Year	No. of days worked in School Year	Part-time or Full-time Status	Position(s) Held

Continuing Contract Status (if applicable): ☐ YES ☐ NO Sick Leave Accumulated: _____

OPEN RECORDS REQUEST

Please provide any information contained in this individual's personnel record evidencing any disciplinary action taken while s/he was employed by your district/agency.

☐ Information enclosed/attached ☐ No disciplinary action on record for this individual

_____ _____ _____

Name & Title of Person Completing Form *Signature* *Date*
(Please Print/Type)

Mark Thomas, Superintendent
205 Airport Road, Elkton, KY 42220
270-265-2436 (phone) / 270-265-5414 (fax)

Review/Revised:4/13/2020