DONATION OF SICK LEAVE REQUEST FORM

Employee Information:

Name: _____ Position: _____
School/Building: _____ Date of Request: _____

Eligibility Confirmation:

I confirm that I am currently absent for thirty (30) consecutive full days or more due to a catastrophic or long-term illness/accident, or the illness/accident of my spouse or minor child. Union agreements state that a person is not eligible for the sick leave bank unless they have been absent for 30 consecutive days or have a catastrophic or long-term illness or accident.

- ☐ Yes
- ☐ No (If "No", please explain):

_____

I have exhausted all of my accumulated sick leave.

- ☐ Yes
- ☐ No (If "No", please explain):

_____

If you are out for 30 consecutive days, have you contracted the treasurer for FMLA, which would require a doctor's certification.

- ☐ Yes
- ☐ No

I understand that the requirement of thirty (30) consecutive days may be waived in extraordinary circumstances at the discretion of the Superintendent.

- ☐ Yes
- ☐ No

Request for Donated Sick Leave:

I am requesting donated sick leave from fellow bargaining unit members. I understand that no bargaining unit member may receive more than fifty (50) donated sick leave days in any one school year.

Medical Information:

Please attach documentation from your physician confirming your illness/accident or that of your spouse/minor child and projected time you will need to take off of work.

Further medical information may be required by the Superintendent to determine eligibility for donated sick leave.

- ☐ I have attached the necessary documentation from my physician.
- ☐ I understand additional information may be requested.

Disability Consideration:

If disability is an option for my situation, I understand it must be pursued first before using donated sick leave.

- ☐ Yes
- ☐ No

Approval:

I understand that the donation of sick leave will only occur with the mutual agreement of the Superintendent and the Association President. Additionally, unused donated days will be returned to the original donating bargaining unit member.

Employee Signature: _____

Date: _____

Superintendent Use Only:

Approved:

- ☐ Yes
- ☐ No
- ☐ Further medical information requested

Superintendent Signature: _____

Date: _____