

CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION FORM

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Follow the instructions on the back of this form: Completed forms should be returned to the payroll department at the Central Office for processing. (PLEASE PRINT)

Donating Employee Information

1. Employee Name: _____
2. Social Security Number: _____
3. Employee Address: _____
4. Employee Telephone(s): _____
5. Employer: _____

Beneficial Employee Information

6. Receiving Employee Name: _____
7. Social Security Number: _____
8. Beneficiary's Employer: _____

Days to be Donated to Beneficiary (not to exceed 30 days)

9. Number of Days to be Donated: _____

Certification of Donating Employee

10. I certify that I hereby donate the above noted number of my sick leave days to the beneficiary employee listed above. My employer has my permission to transfer the indicated number of sick leave days to the employer of the beneficiary for his or her use due to catastrophic illness/injury as defined by Act 93-753. It is my understanding that my sick leave balance will be reduced by the specified number of days hereon and that the donated days will not be returned to me.

Donating Employee's Signature: _____ Date: _____
Witness: _____ Date: _____

11. I certify that the donating employee's information listed above is correct to the best of my knowledge.

Authorized Signature: _____ Date: _____
Title: _____

Receipt of Beneficiary Employer

12. The above noted number of sick leave days have been credited to the sick leave account of the beneficiary employee.

Authorized signature: _____ Date: _____
Title: _____