APPENDIX A

REQUEST TO RECEIVE DONATED LEAVE

Please Type or Print

TO BE COMPLETED BY APPLICANT OR PERSONAL REPRESENTATIVE OF APPLICANT

Name (Last, First, MI)	Employee ID Number:	
Department Name:	Work Location:	Work Phone:

Employee Status:

☐ Full-Time ☐ Part-Time Number of Hours Per Week: _____

Leave Balances at End of Last Pay Period:

Sick _____ Comp Time _____ Number of Hours of Leave without Pay Anticipated for this Medical Event:

Vacation _____ Personal Days _____ _____

[ ] Please broadcast a county-wide request for me.
Optional: Brief summary of any information to be released in general county announcement:

SIGNATURE OF RECEIVING EMPLOYEE

_____ / /
Signature Date

SIGNATURE OF PERSONAL REPRESENTATIVE OF RECEIVING EMPLOYEE

Your "Personal Representative" will be responsible for coordinating your donated leave.

_____ _____
Name - Please Print Relationship to Employee

_____ / /
Signature Date

SIGNATURE OF RECEIVING EMPLOYEE'S SUPERVISOR

_____ _____
Name - Please Print Phone Number

_____ / /
Signature Date

FOR USE BY DEPARTMENT OF EMPLOYEE SERVICES

EVENT	DATE	STATUS	INITIALS OF PERSON PROCESSING
FML Request Received By DES			
Medical Documentation Received			
Request for Donated Leave Received by DES			
Accrued Leave Verified			
Date Paid Leave Exhausted			
End of FML Entitlement			
Disability and Workers' Comp. eligibility?			
Payroll Notified			
Notice Sent To Employee			

PAYROLL INFORMATION SECTION

This Request is:

Approved*

Denied

____/____/____
Date

*Maximum Amount of Donated Leave Eligible for Transfer: _____

DES Approval: _____ ____/____/____
Date