

SICK LEAVE TRANSFER REQUEST

DATE: _____

NAME OF RECEIPIENT: _____

SOCIAL SECURITY NUMBER: _____

DEPARTMENT: _____ TITLE: _____

ANNUAL SALARY: \$ _____

AMOUNT OF AVAILABLE SICK LEAVE AS OF _____, _____
DATE HOURS

REASON FOR THE REQUEST: _____

DOCTORS CERTIFICATE AND PROGNOSIS ATTACHED: YES _____ NO _____

STATEMENT BY RECIPIENT: I request that a solicitation of sick leave be conducted on my behalf. As a result of an illness or injury, I will likely be off work until _____, based on my doctor's prognosis, and that I do not have enough earned sick leave or vacation time to cover that absence. Any unused donated sick leave will be transferred by me to another city employee should that need arise.

DATE SIGNATURE OF RECIPIENT

DEPARTMENT HEAD AUTHENTICATION: I have reviewed this application for transfer of sick leave to the account of _____ and recommend (approval) (disapproval).

DATE SIGNATURE

HUMAN RESOURCES DEPARTMENT AUTHENTICATION: I have reviewed the application and the recipient's sick leave and vacation time and recommend (approval) (disapproval).

DATE SIGNATURE

APPENDIX A