ALBERTVILLE CITY SCHOOLS

Catastrophic Sick Leave Transfer Authorization

PLEASE PRINT

Section 1: To be completed by Recipient

Employee Name: ____

Last four digits of Social Security Number __________

Employee ID Number __________

Section 2: To be completed by Donor

Employee Name: ____

Last four digits of Social Security Number __________

Donor Address: ________________________________ Phone: ______________

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Employer: ____________________________________ Phone: ______________

Number of Days to be donated: __________ (Not to exceed 30 days)

I certify that I hereby donate the above noted number of my sick leave days to the beneficiary listed above. My employer has my permission to transfer the indicated number of Sick Leave Days to the employer of the recipient 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.

Donor Signature: ________________________________ Date: ____________

Signature of Witness: ____________________________ Date: ____________

Section 3: To be completed by Central Office of Donor

To the best of my knowledge, I hereby certify that the donating employee's information listed above is correct.

Authorizing Signature: ____________________________ Date: ____________

Section 4: To be completed by Central Office of Recipient

The above noted number of Sick Leave days, as indicated in Section 2, has been credited to the Sick Leave account of the recipient. A copy of this form has been given to the recipient.

Authorizing Signature: ____________________________ Date: ____________