CATASTROPHIC LEAVE TRANSFER AUTHORIZATION

DONATING EMPLOYEE INFORMATION

1. EMPLOYEE NAME:
2. EMPLOYEE ADDRESS:

3. EMPLOYEE TELEPHONE:
4. EMPLOYER:

BENEFICIARY EMPLOYEE INFORMATION

5. RECEIVING EMPLOYEE NAME:
6. BENEFICIARY'S EMPLOYER:

NUMBER OF DAYS TO BE DONATED TO BENEFICIARY (NOT TO EXCEED 30 DAYS)

7. NUMBER OF DAYS DONATED:

CERTIFICATION OF DONATING EMPLOYEE

8. I certify that I hereby donate the above 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/her use due to a catastrophic illness as defined by ACT 93-783. 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:

CERTIFICATION OF DONATING EMPLOYER

9. I hereby certify that the donating emplyee's information listed above is correct to the best of my knowledge.

Authorized signature:

Title:

RECEIPT OF BENEFICIARY EMPLOYER

10. The above noted number of sick leave days have been credited to the sick leave account of the beneficiary employee. (Please give a copy of this form to the beneficary employee.)

PLEASE SUBMIT THIS FORM TO: Local School Payroll Person