SICK BANK DONATION
TRANSFER AUTHORIZATION

Please Print:

DONATING EMPLOYEE INFORMATION

Employee's Name _____ Employer _____

_____

_ Employee's Street Address City Zip Phone Number

BENEFICIARY EMPLOYEE INFORMATION

Receiving Employee's Name _____

Beneficiary's Employer: _____

Number of days to be donated (not to exceed **30** days) _____

CERTIFICATION OF DONATING EMPLOYEE

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

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

_____

Authorized Signature Title

RECEIPT OF BENEFICIARY EMPLOYER

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

_____

Authorized Signature Title

PLEASE SUBMIT this form to your Local School Payroll Person