FLOWING WELLS SCHOOLS
PERSONAL ILLNESS LEAVE DONATION FORM

DIRECTIONS
Please read carefully the information below, sign and submit to Human Resource office.

Employee Name: ____________________________________ **Date:** ________________________

School/Department: __________________________________ **Employee ID#** _______________

I desire to make a donation of sick leave and verify the following :

- I have currently accrued twenty (20) or more days of sick leave.
- I understand that if I have 30 or more days, I may donate no more than five (5) days of personal illness leave; if I have 25 or more days, I may donate no more than four (4) days of personal illness leave; and if I have 20 or more days, I may donate no more than three (3) days of personal illness leave in any contract year for no more than 3 years.
- I understand that my donated leave becomes the property of the receiving employee and **will not** be returned to me if unused.
- I understand that days of leave, not my actual wage/salary, will be dontated.
- I am not donating leave to my immediate supervisor.
- Information relative to this donation will remain confidential.
- I make this donation voluntarily.

Number of Days to be Donated __________________

Employee to Receive Donated Days ____

Employee's Signature ____ **Date:** ___________________

☐ Approved ☐ Disapproved

Director of Human Resources: __________________________________ **Date:** ___________________

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<u>For Office Use Only</u>

Number of Days Available ___________ Donating # of days__________ # of Remaining Accumulated Sick Leave Days ________

Business Office (Payroll) ☐ Verified

White Copy: Business Office **Yellow Copy: Human Resource Office** **Pink: Employee Copy**

Revised JAN 2010 **9-FW30135**
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