# SICK LEAVE DONATION FORM

Name of Donor: ______________________________

Department: ______________________________

Employee ID#: ______________________________

Amount of Donation to be credited to Recipient: __________

(Employee must have 40 hours remaining after donation. Minimum amount employee may donate is 8.0 hours)

Recipient: ______________________________

Department: ______________________________

Employee ID#: ______________________________

I hereby certify that this donation is given without expectation or promise for any purpose other than that authorized. I further understand that I am consenting to receiving this donation because of a medical necessity. __________ Recipient Initials

______________________________ ______________

Donor Date

The original should remain with the Donor's personnel file. A copy should be transmitted to the County Treasurer so that the sick leave balances may be adjusted.

______________________________ ______________

Department Head Date

______________________________ ______________

County Judge Executive Date