EMPLOYEE RELATIONS SERVICES

Telephone No. (562) 997-8220* FAX No. (562) 997-8283

APPENDIX C

REQUEST TO PARTICIPATE IN SICK LEAVE DONATION PROGRAM

Date: ____________________

To: ____________________
Principal/Site Administrator

Subject: Sick Leave Donation Program

I hereby request that a *Request for Donations, Extended Sick Leave* be sent to District employees on my behalf. I will soon exhaust the sick leave and vacation that I have accrued. I understand that the purpose of this program is to provide me with the opportunity to benefit from sick leave donations due to a catastrophic illness or injury.

☐ Medical verification of my catastrophic illness/injury from my attending physician is attached to this form (required).

Name ____

Position Title ____________________ Department/Site ____________________

Date Submitted ____________________ Signature ____________________

RECOMMENDATION OF PRINCIPAL/SITE ADMINISTRATOR

☐ The employee listed above has my ***recommendation*** to accept donated sick leave.

☐ The employee listed above is denied ***my recommendation*** for the use of donated sick leave.

____________________	____________________	____________________
Print Name of Principal/ Site Administrator	Signature	Date of Action

APPROVAL OF ASSISTANT SUPERINTENDENT/DEPUTY SUPERINTENDENT/ CHIEF BUSINESS AND FINANCIAL OFFICER

☐ The employee listed above is approved to receive donated sick leave.

☐ The employee listed above is denied the use of donated sick leave.

____________________	____________________	____________________
Print Name	Signature	Date of Action

DO NOT ATTACH THIS FORM FOR DISTRIBUTION TO EMPLOYEES