

## SICK LEAVE SHARING FORM

To be completed by DONOR

Name of Donor: \_\_\_\_\_

Department or Elected Official's Office: \_\_\_\_\_

Maximum amount of Donor's Leave (in excess of 75 hours) to be credited to Recipient: \_\_\_\_\_

Name of Recipient: \_\_\_\_\_

Department or Elected Official's Office: \_\_\_\_\_

I hereby certify that this donation is given without expectation or promise for any purpose other than that authorized by Sick Leave Policy enacted by the Franklin County Fiscal Court on June 14, 1991.

\_\_\_\_\_  
Signature of Donor

\_\_\_\_\_  
Date

This is to certify that the employee named above has a sufficient sick leave balance to donate the hours indicated under the provisions of Sick Leave Policy enacted by the Franklin County Fiscal Court on June 14, 1991.

The recipient has been approved to receive donated sick leave in accordance with the Franklin County Administrative Code, Section 3.45.

\_\_\_\_\_  
Signature of Supervisor  
and or Agency Head

\_\_\_\_\_  
Date

The Donor's Agency Head must forward one copy of this form to the Recipients Agency Head and one copy to the County Judge/Executive, for inclusion in the employee's Personnel File.