

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 signature and inclusion in the employee's Personnel File.

Signature of County Judge/Executive
or Authorized Designee

Date