# SICK LEAVE SHARING FORM

To be completed by RECIPIENT

Name of Recipient: _____

Department or Elected Official's Office: _____

Amount of Sick Leave Needed: _____

Please provide a reason transferred leave is needed, including a brief description of the nature, severity, and anticipated duration of the medical emergency.

_____

_____

_____

_____

Please attach certification by one or more physicians of the medical reason that employee will be unable to perform the duties and responsibilities of his/her position for ten (10) or more consecutive working days.

_____

Signature of Recipient or Representation Date

The above named employee has been approved to receive donated sick leave in accordance with the provisions of Sick Leave Policy enacted by the Franklin County Fiscal Court on June 14, 1991.

_____

Signature of Supervisor and or Agency Head Date

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

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Signature of County Judge/Executive or Authorized Designee Date