OKCPS Sick Leave Donation/Request Form

DONATION INFORMATION

Last Name _____ First Name _____ Employee ID _____

# of Days Donating _____ Name of Employee to Which I am Donating _____

I hereby donate the above stated number of accumulated sick leave to the specified employee for their immediate use. I realize that any days not used by the individual listed above will be returned to me on a pro-rated basis. I have verified that the donation of the above days will not take me below the minimum threshold of 30 days in my own sick leave balance.

Signature of Donator _____ Date _____

REQUEST INFORMATION

Last Name _____ First Name _____ Employee ID _____

# of Days Requesting _____ Department/Location _____ Supervisor Name _____

I hereby request the above stated number of days of sick leave to be donated to me through the District's Leave Sharing Program.

Attached to this form is a medical certificate from a licensed physician/health care provider verifying the diagnosis, prognosis, and expected duration of the condition for which I am requesting this leave.

I hereby certify that, to the best of my knowledge, I have previously abided by the District's current leave policies, that the nature of the condition is such that I have used or will use all other leave available to me, and that the condition has caused or is likely to cause me to take leave without pay or to terminate my employment with OKCPS.

Signature of Requestor _____ Date _____

HR USE ONLY

☐ Approved

☐ Denied

Notes: _____

HR Official Signature _____ Date _____