CATASTROPHIC LEAVE TRANSFER AUTHORIZATION

Donating Employee Information

1. Employee Name (Last, First, MI)
2. Social Security Number
3. Employee Address   City   State   Zip
4. Employee Telephone(s)   Home (   )   Work (   )
5. Jurisdiction
6. Department
7. Employee Classification
8. Rate of Pay

Beneficiary Employee Information

9. Receiving Emp. Name
10. Social Security
11. Beneficiary's Employer

Hours to be Donated to Beneficiary
(Increments of 8 hrs)
Maximum Donation of 240 hrs to be used Jan - Dec

12. Number of hours to be donated:
    (Sick) Hours   (Vacation) Hours

Certifying of Donating Employee

13. I certify that I hereby donate the above noted number of hours leave to the beneficiary employee listed above. My employer and the Personnel Board have my permission to transfer the indicated number of hours leave to the employer of the beneficiary for his or her use for a catastrophic illness. It is my understanding that my leave balance will be reduced by the specified number of hours hereon as used by the beneficiary employee and that the donated hours will not be returned to me.

    Donating Employee's Signature: ______________________________________ Date: ______________________

    Witness: ____ Date: ______________________

Certification of Donating Employer

14. I hereby certify that the donating employee's information listed above is correct to the best of my knowledge.

    Authorized Signature:____ Date: _______________________

    Title: ____
    Appointing Authority or Department Head

Certification of Beneficiary Employer

15. I approve the above noted number of leave hours to be credited to the account of the beneficiary employee as needed.

    Authorized Signature: ____ Date: _______________________

    Title: ____

Personnel Director's/Asst. Director's Signature   Date of Approval

Office Use Only