College of Micronesia-FSM

APPLICATION FOR DONATEED SICK LEAVE

1. NAME OF REQUESTTING EMPLOYEE	2. DEPARTMENT/CAMPUS/OFFICE/DIVISION
3. NUMBER OF SICK LEAVES HOURS REQUESTED	4. DATES FOR WHICH REQUESTED LEAVE IS TO BE APPLIED

I the recipient employee, hereby acknowledge that upon approval of the application such leaves hours will be credited to me for use pursuant to the donated leave policy.

Print Name: _____ Signature: _____ Date: _____

DOCUMMENTS SUBMITTED: ☐ Application Form ☐ Physician's Certification ☐ Leave Summary

SUPERVISOR'S ENDORSMENT: ☐ Support ☐ Do not support

COMMENTS: _____

_____

Print Name: _____ Signature: _____ Date: _____

DONOR USE ONLY:

NAME OF DONOR:	NUMBER OF SICK LEAVE HOURS TO BE DONATED:
	DEPARTMENT/CAMPUS/OFFICE/DIVISION

I, the donor employee, am freely and willing, and not for financial gain, forfeiting all rights to the leave hours as indicated above to the recipient employee. I further understand that upon approval these leaves are no longer available to me pursuant to the donated leave policy.

Signature: _____ Date: _____

FOR HUMAN RESOURCES USE ONLY:

REQUESTING EMPLOYEE MET THE FOLLOWING CRITERIA:

☐ Full-time ☐ Has a continuing catastrophic disability

☐ Completed initial contract ☐ Exhaustion of leave verified ☐ Physician's certification attached

COMMENTS: _____

_____

HR certification: _____ Date: _____

FOR PAYROLL USE ONLY:

REQUESTING EMPLOYEE HAS:

☐ Exhausted all compensatory time

☐ Exhausted all accumulated leaves

DONOR HAS:

☐ Accrued at least 30 sick leave days

☐ A balance of 10 sick leave days after donating

COMMENTS: _____

_____

Payroll certification: _____ Date: _____

Copy to Donor, Recipient, Supervisor, Business Office and Human Resources Office