Kent **County**

DONATED LEAVE REQUEST FORM

Name_____ e-mail _____

Department/Division_____ Home Phone # _____

If absence is FMLA eligible, please retain one week (40 hours) of sick leave – YES or NO
If 'yes' is circled, I understand I will not be paid unless donated or accrued leave exceeds 40 hrs.

I respectfully request the donation of sick leave as provided in the Kent County Donated Leave Policy. I hereby acknowledge and certify the following:

1) I or a member of my family have a Family and Medical Leave Act qualifying illness or injury;

2) I have received a copy of the Kent County Donated Leave Policy;

3) I have or will have used all my personally accrued sick and vacation leave*;

4) I understand that I must use and receive payment for at least 10 sick leave days per month, if 10 or more days have been donated and credited to my sick leave account;

5) I understand that I will not accrue vacation or sick leave while receiving donated leave (except during FMLA leave);

6) I understand that I cannot return any unused donated leave, but will receive only those blocks of time needed;

7) I understand that in order for me to receive donated leave from Kent County employees it will be necessary for donors and potential donors to be informed about my personal and private reasons for requesting donated leave;

In addition, I request that any donated leave be paid to me in the following manner:

_____ please pay me for each day donated; OR

_____ please pay me for _____ # of days per month (minimum of 10).

Please *circle* payment format: **pay at half pay** **pay at full day**

_____ _____
Signature Date

Reviewed and Approved:

_____ _____
Personnel Director Date
Revised (11/05/13)