

Superintendent's Shared Sick Leave Requesting or Donating Form

Requesting Leave Days

Date _____

Name _____

I hereby request _____ days of sick leave be donated to me through the District's Sick Leave Sharing Program. Attached to this form is a medical certificate from a licensed physician or health care provider verifying the severe or extraordinary nature and expected duration of the condition.

I hereby certify, that to the best of my knowledge, I have previously abided by the District's 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 employment.

Signature of Employee

Date _____

Donating Leave Days

Date _____

Name _____

I hereby donate _____ days of my accumulated sick leave to _____

for that person's immediate use. I realize that any days not used will be returned to me.

Signature of Employee

Date _____

Return to superintendent.

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Adopted: June 03, 1996

Revised: January 12, 1998
January 05, 2004
June 07, 2004

Legal Reference:

Cross Reference:

District #001, Woods County, Oklahoma