CLINTON MASSIE LOCAL SCHOOL DISTRICT
SICK LEAVE DONATION PROGRAM APPLICATION

Name: _____ Address: _____
Phone Number: _____ _____
Position and Building: _____

Have you received Sick Leave Donation benefits previously this year? YES NO
If yes, provide date(s) _____

Number of sick leave days available as of date of application: _____
Date sick leave days will be exhausted: _____
Have you applied for the 15 day advance of sick leave days? _____
If no, you must apply for and use the 15 day advance before being eligible for this program.
If yes, the date 15 day advance will be exhausted: _____

Last day worked or anticipated date of leave: _____
Anticipated date of return: _____

EMPLOYEE AUTHORIZATION

I understand that my application for the sick leave donation program must be accompanied by a completed Attending Physician's Statement form in order to be considered by the sick leave donation committee. I hereby authorize the release of otherwise confidential medical information by my physician(s) to the committee for limited purpose of consideration of my application.

_____ _____
Date Employee Signature

THIS APPLICATION MUST BE ACCOMPANIED BY THE ATTENDING PHYSICIAN'S STATEMENT FORM COMPLETED BY THE ATTENDING PHYSICIAN(S).

TO BE COMPLETED BY SICK LEAVE DONATION COMMITTEE:
(Spreadsheet must be attached listing donor names and number of days being donated)

First Request of 30 days Second Request of 30 days
(Circle one)

Signatures of all committee members:

_____ _____
_____ _____

Acknowledged for Processing:

_____ _____
Superintendent Date

PAYROLL ADMINISTRATOR

Date Received: _____ Date Posted: _____