

## CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION

**DONATING Employee Information**
**(PLEASE PRINT OR TYPE FORM)**

1. Employee Name:	
2. Employee Address:	
3. Employee Telephone(s):	
4. Employer:	

**BENEFICIARY Employee Information**

5. Employee Name:	
6. Employer:	

**Days to be Donated to Beneficiary (not to exceed 30 days)**

7. Number of days to be donated:	The donated days may be used to repay days borrowed from the Sick Leave Bank. <input type="checkbox"/> No <input type="checkbox"/> Yes
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**Certification of DONATING Employee**

8. I certify that I hereby donate the above noted number of my sick leave days to the beneficiary employee listed above. My employer has my permission to transfer the indicated number of sick leave days to the employer of the beneficiary for his or her use due to a catastrophic illness/injury as defined by Act 93-753. It is my understanding that my sick leave balance will be reduced by the specified number of days hereon and that the donated days will not be returned to me.	
Donating Employee's Signature:	Date:
Witness:	Date:

**Certification of DONATING Employer**

9. I hereby certify that the donating employee's information listed above is correct to the best of my knowledge.	
Authorized Signature:	Date:
Title:	

**Receipt of BENEFICIARY Employer**

10. The above noted number of sick leave days has been credited to the sick leave account of the beneficiary employee. (Please give a copy of this form to the beneficiary employee.)	
Authorized Signature:	Date:
Title:	