

**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**  
**REQUEST FORM TO DONATE SICK LEAVE HOURS TO A FAMILY MEMBER**

**Return Completed Form to Receiving Employee's Payroll Secretary**

PLEASE TYPE OR PRINT IN INK

**DONATING EMPLOYEE INFORMATION:**

\_\_\_\_\_  
EMPLOYEE ID #

\_\_\_\_\_  
LAST NAME, FIRST NAME, M.I.

\_\_\_\_\_  
POSITION NAME

\_\_\_\_\_  
WORKSITE

**(Please select one)**

**Number of**  
**hours authorized\*:** \_\_\_\_\_

**Relationship to**  
**receiving employee:**      Husband    Wife    Brother    Sister  
                                         Daughter    Son    Father    Mother

*\*School Board Rule requires that donor employees of sick leave donated shall retain a minimum of ten (10) days of available sick leave after the sick leave donation is deducted.*

**Certification of Donating Employee:**

I certify that I hereby donate the above number of my sick leave hours to the receiving family member listed below. The School District of Osceola County, Florida is authorized to transfer the indicated number of sick leave hours to the receiving employee for his/her use for leave pursuant to School Board Policy governing the use of sick leave as defined in the guidelines for authorizing sick leave donations to relatives. It is my understanding that my sick leave balance will be reduced by the specified number of hours hereon and that the donated hours will not be returned to me except as noted in the Guidelines. ***For Sick Leave Bank Members only:*** I understand that if I am a member of the Sick Leave Bank, in the event that I should need to make a withdrawal, any time donated to another employee will be deducted from the maximum days that I am eligible to draw.

\_\_\_\_\_  
Donating Employee Signature

\_\_\_\_\_  
Date

**EMPLOYEE RECEIVING SICK LEAVE:**

\_\_\_\_\_  
EMPLOYEE ID #

\_\_\_\_\_  
LAST NAME, FIRST NAME, M.I.

\_\_\_\_\_  
POSITION NAME

\_\_\_\_\_  
WORKSITE

**Agreement and Authorization of Receiving Employee:**

I agree to accept the donation of sick leave hours as authorized by my family member listed above. In the event I do not use all the donated leave hours, any remaining balance shall be returned to my family member at the end of the fiscal year.

\_\_\_\_\_  
Receiving Employee Signature

\_\_\_\_\_  
Date

**FOR PAYROLL SECRETARY AND HUMAN RESOURCES DEPARTMENT USE ONLY:**

**Run #:** \_\_\_\_\_

**Relationship Confirmation:** \_\_\_\_\_

**# of Hours Required For Run** \_\_\_\_\_

**Payroll Secretary Signature**

**Date Entered/HR Initials:** \_\_\_\_\_