THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
DONATION OF SICK LEAVE TO FAMILY MEMBERS/ COLLEAGUES REQUEST FORM

I, _____, personnel #_____ agree to donate sick leave from my earned/
Employee Donor Name

accrued sick leave balance to _____ , personnel # _____,
Employee Recipient Name

who is my: CHILD. **(select from list)**

Employee Donor Location _____ Position_____

Employee Recipient Location _____ Position_____

Beginning Date of Donated Sick Hours _____ Ending Date of Donated Sick Hours_____

Number of Hours Donated _____ **(At the time of an employee's donation to a qualified family member or colleague, the donated sick leave day shall be converted to a monetary sum by multiplying the day donated times the donor's daily base rate of pay at the time of the donation. The resulting value shall be credited to the recipient for use as sick leave.)**

NOTE: This donation is subject to terms/conditions outlined in Policy 4400 or the applicable Collective Bargaining Agreement.

I understand and acknowledge that donated sick time will be used in accordance with the conversion method stated above.

Employee Donor Signature	**Date**	**Employee Recipient Signature**	**Date**
Supervisor of Employee Donor Signature	**Date**	**Supervisor of Employee Recipient Signature**	**Date**

FORM #4697
Created: 11/01/2001
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ORIGINAL – Payroll Department