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

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

accrued sick leave balance to _____, personnel # _____, who is my:
Employee Recipient Name

❒ spouse, ❒ child, ❒ parent, or ❒ sibling (check one).

Employee Donor Location _____ Position_____

Employee Recipient Location _____ Position_____

Beginning Date of Leave _____ Ending Date of Leave_____

Total Sick Leave hours earned and not used as of beginning date: _____

Number of Hours Donated _____ (At the time of an employee's donation to a qualified family member, 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 ORIGINAL-Payroll

COPY- Employee Donor
Employee Recipient
Supervisor – Donor
Supervisor – Recipient

Created 11/2001