

Independent School District 15

Human Resources
4115 Ambassador Boulevard NW, St. Francis, MN 55070
763-753-7040 • www.isd15.org

Employee Leave Donation Request

Employee Information

Name _____ Employee ID _____ Hire Date _____

Leave donation for which I'm requesting eligibility: Annual Sick

I am applying to be eligible for the leave sharing program. I understand that any District employee(s) may donate leave to me as follows:

1. Annual leave if I, a relative, or household member is suffering from an extraordinary or severe illness, injury, impairment, physical or mental condition that has caused or is likely to cause me to take a leave of absence without pay or terminate employment.
2. Sick leave if I am suffering from an extraordinary or severe illness, injury, impairment, physical or mental condition that has caused or is likely to cause me to take a leave of absence without pay or terminate employment.

As of _____ Annual leave balance _____ Sick leave balance _____

I am requesting _____ (number of hours) for donation.

I understand that leave donated to me may only be used for the purpose specified and is not payable in cash. I have abided by the policies regarding the use of sick and annual leave. I have not or will not use more than four months of shared leave in any 12 month period.

Employee signature _____ Date _____

I agree that the employee has abided by policies regarding use of sick and annual leave.

The employee is at work. Yes No The employee has not been at work since _____

Department head signature _____ Date _____

Attach a completed Certification of Health Care Provider from a licensed physician verifying the severe or extraordinary nature and expected duration of condition.

Office Use Only

Human Resources request is: Approved Denied

Reason for denial:

Human Resources signature _____ Date _____