ST. CLAIR COUNTY BOARD OF EDUCATION
410 Roy Drive, Ashville, AL 35953

CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION

DONATING EMPLOYEE INFORMATION

Employee Name: ______________________________

Social Security Number: ______________________________

Employee Telephone: ______________________________

Employer: ______________________________

BENEFICIARY EMPLOYEE INFORMATION

Receiving Employee Name: ______________________________

Social Security Number: ______________________________

Beneficiary's Employer: ______________________________

Number of Days to be Donated to Beneficiary (not to exceed 30 days) ____________

CERTIFICATION OF DONATING EMPLOYEE

I certify that I hereby donate the above donated number of 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/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.

Signature of Donating Employee's and Date: ______________________________

Signature of Witness and Date: ______________________________

CERTIFICATION OF DONATING EMPLOYER

I hereby certify that the donating employee's information listed above is correct to the best of my knowledge.

Authorized Signature and Date: ______________________________

Title: ______________________________

RECEIPT OF BENEFICIARY EMPLOYER

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 and Date: ______________________________

Title: ______________________________