ST. LUCIE PUBLIC SCHOOLS

DONATION OF ACCUMULATED SICK LEAVE

BY A ST. LUCIE COUNTY SCHOOL BOARD EMPLOYEE

DATE _____

I, _____, _____,
Print Donor's Name / Position / Worksite Last 4 Digits of Donor's SSN

authorize, _____,
Print Recipient's Name / Position / Worksite

a School Board employee (not an immediate family member) to use _____ days of
indicate number of days

my sick leave accumulated as of this date. I understand that these days, if used, will no longer be available to me and will not be calculated in any terminal pay to which I may be entitled under s.231.40(3) Florida Statute or elsewhere in School Board Policy. Donated sick leave unused during the requiring absence will be returned in accordance with St. Lucie County School Board Policy 6.549(4)(d).

_____ _____
Signature of Donor Donor's email address

FOR HR USE ONLY

Date & Time Received _____ Dates of Absence_____

Leave Request for Recipient created ☐ -YES_____ (How many days/hours requested) ☐ -NO

Donor's balance of sick leave days: _____ Recipient's balance of sick leave days/hours: _____

☐Approved Donor's worked hours per day: _____ Recipient's worked hours per day: _____

☐Denied ☐Employee must maintain a 5 day balance ☐your donation exceeds the requested need at this time

Human Resources Administrator Signature & Date _____

HR Notes: _____
_____
_____
_____

cc: Payroll
Human Resources
Authorizing Employee

PER0185 Rev. 12/2016