



City of Mission
Sick Leave Sharing Donation

***** **EMPLOYEE DONOR** *****

Employee Donor: _____ Employee No. _____
(First Name) (Last Name) (M)

Job Title: _____ Department: _____

***** **BENEFICIARY EMPLOYEE** *****

Pursuant to the Sick Leave Sharing policy (Policy No. 600.07), I hereby volunteer to donate

_____ hours of my sick leave, vacation leave, or comp time to:

_____, _____
(First Name) (Last Name) (M) (Job Title)

Note: Beneficiary Employee receiving hours must be on approved family and medical leave.

***** **CERTIFICATION** *****

I hereby certify that I am donating the specified hours on a voluntary basis to the employee identified on this Sick Leave Sharing Donation form. I understand and agree to the terms of the Sick Leave Sharing policy. The donated hours will remain in my leave balance until they are used by the Beneficiary Employee.

Employee Donor Signature: _____ Date: _____

Forward the completed Sick Leave Sharing Donation form to the Human Resources Director

***** **HUMAN RESOURCES DEPARTMENT** *****

Received By: _____ Date: _____

Approved Beneficiary Employee FMLA Approved Dates: _____
 Denied Reason: _____

Human Resources Director Signature: _____ Date: _____

*Submittal of this Sick Leave Sharing Donation form does not constitute automatic approval of donated hours.