CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION FORM
SYLACAUGA CITY BOARD OF EDUCATION
Sylacauga, Alabama

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***DONATING EMPLOYEE INFORMATION***

NAME OF EMPLOYEE _____
SCHOOL/WORK SITE _____
HOME ADDRESS _____
SOCIAL SECURITY # _____SCHOOL/WORK SITE PHONE # _____

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***BENEFICIARY EMPLOYEE INFORMATION***

NAME OF EMPLOYEE_____
SCHOOL/WORK SITE _____
HOME ADDRESS _____
SOCIAL SECURITY # _____SCHOOL/WORK SITE PHONE # _____

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***DAYS TO BE DONATED***

***NOTE: Not more than thirty (30) days may be donated.***

**NUMBER OF DAYS TO BE DONATED:** _____

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***CERTIFICATION OF DONATING EMPLOYEE***

I certify that I hereby donate the above number of my sick leave days to the beneficiary employee listed above. The Board has my permission to transfer the indicated number of sick leave days to the employee sick leave bank for the specific use of the employee listed above 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 specific number of days hereon donated and that the days will not be returned to me.

SIGNED DATE _____ DATE_____

**DONATING EMPLOYEE**

WITNESSED BY DATE _____ DATE_____

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***CERTIFICATION OF THE BOARD***

I hereby certify that the donating employee's information listed above is correct to the best of my knowledge, and the above number of sick leave days donated have been credited to the sick leave account of the beneficiary employee.

SIGNED DATE _____ DATE_____

**AUTHORIZED PERSON**

TITLE OF AUTHORIZED PERSON _____

**ORIGINAL - Chairman, Sick Leave Bank**
**DUPLICATE - Central Office**
**TRIPLICATE - Donating Employee**