SARPY COUNTY

CATASTROPHIC ILLNESS DONATION REQUEST FORM

EMPLOYEE INFORMATION

Completed by the employee or an authorized individual acting on the employee's behalf

Employee Name: _____ Date: _____

Department: _____ Division: _____

Type of Request: ☐ Employee's health ☐ Immediate family member's health

If family member, please provide name: _____

Family member relationship: ☐ Spouse ☐ Child ☐ Parent ☐ Self

Donation Source: ☐ Department ☐ County-wide

Donation Email: ☐ Employee ☐ Department Head ☐ HR

I respectfully request vacation/sick leave donations as outlined in the Personnel Rules and Regulations: Rule 12: Types of Leave; Regulation 4: Catastrophic Illness Leave Donation Program.

- *I understand that I must submit to the Human Resources Department, along with this form, medical certification unless current FMLA medical certification is on file.*
- *I understand that if I choose to disclose specifics pertaining to the nature of the health condition that I will be required to provide written authorization to the Human Resources Department.*
- *I have read, understand, and I agree to the requirements and provisions of the Catastrophic Illness Leave Donation Program.*

_____ _____

Employee/Authorized Individual Signature Date

If employee did not sign form, please indicate below your relationship to the employee and any phone number(s) where you may be reached:

_____

HUMAN RESOURCES USE

Request received: _____ Medical certification received: ☐ Yes ☐ No

Leave benefits verified: ☐ Yes ☐ No Determination: ☐ Approved ☐ Denied

_____ _____

Consecutive Days Off (minimum 10) before donated leave usage Verified (HR rep initial)

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Human Resources Director - Designee Date

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