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|  | **State of Florida**  **INTERAGENCY SICK LEAVE TRANSFER**  **REQUEST TO DONATE** |

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| **Part I - Request to Donate Sick Leave Hours - Donor Information** | | | | |
| *I certify that I have read and understand the requirements and provisions of Rule 60L-34.0042(5), F.A.C., and that I am eligible and willing to donate my personal sick leave credits as specified below. I further understand that the donated sick leave credits will be* ***permanently*** *deducted from my sick leave balance at the end of the pay period and if unused, will be returned.* | | | | |
| Print Name: | | | People First Employee ID#: | |
| Agency/Division/Bureau or District/Region/Institution: | | | | |
| Work Telephone Number: (     ) | | |  | |
| I authorize my employer to transfer       hours of sick leave to the following recipient (minimum of 8 hours). | | | | |
| *I certify that I am related to the recipient by birth, marriage or other legal relationship, as specified in Rule 60L-34.0042(5)(b), F.A.C., (spouse, parents, grandparents, brothers, sisters, children and grandchildren of either the employee or the spouse).* | | | | |
| Signature | |  | Date | |
| **RECIPIENT INFORMATION** | | | | |
| Recipient's Name: | | | People First Employee ID# (if known): | |
| Agency/Division/Bureau or District/Region/Institution: | | | | |
|  | | | | |
| **Part II - For Personnel Office(s) Use** | | | | |
| **Recipient's Agency** | | | **Donor's Agency** | |
| Date:   /  / | | | Date:   /  / | |
| **Send To:**  Sick Leave Transfer (SLT) Plan Administrator  Personnel Office/Human Resources | | | **Send To:**  SLT Plan Administrator  Personnel Office/Human Resources | |
| Department of | | | Department of | |
| Telephone: | Fax: | | Telephone: |  |
| Hours Credited: | PPE:   /  / | | Fax: |  |
| Hours Credited: | PPE:   /  / | | Hours Charged: | PPE:   /  / |
| Hours Credited: | PPE:   /  / | | Approved | Disapproved |
| Hours Credited: | PPE:   /  / | | SLT Administrator's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Approved Per Criteria | Disapproved Per Criteria | | Print SLT Administrator's Name: | |
| SLT Administrator's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **To return unused sick leave to the donor,**  **complete Part III of this form.** | |
| Print SLT Administrator’s Name: | | |

**DMS-SLDONATIONTEMPLATE Rev. 10/15**

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| **Part III - Return of Unused Sick Leave Hours** | | | |
| **To:** |  | |  |
|  | Agency | |  |
|  | Sick Leave Transfer Plan Administrator | |  |
|  | Address | |  |
| **From:** |  | |  |
|  | Agency | |  |
|  | Sick Leave Transfer Plan Administrator | |  |
|  | Signature | |  |
| **Please credit** **hours back to:** | |  | |
|  | | Employee Name | |
| **People First Employee ID#:** | | | |