Request to Receive Donated Sick Leave through the Transfer Plan or Sick Leave Pool

IMPORTANT: A completed Request **and** Medical Certification, must be received by Krystal.Hill@deo.myflorida.com or Candace.McWilliams@deo.myflorida.com, no later than the 15th calendar day of the following month for which sick leave benefits are being requested.

SECTION I – EMPLOYEE INFORMATION

Name: _____

People First ID: _____

E-Mail (personal): _____

Phone No.: _____

SECTION II – BENEFIT

I request to receive:

☐ Sick Leave Pool – SLP
(I have verified I am a member of the COM SLP)

☐ Sick Leave Transfers – SLT
(I have solicited donations from my coworkers/friends/family)

What month(s) are you requesting benefits?

_____

Are you requesting full pay?

☐ Yes

☐ No, # of hours: _____

Last Date Worked:

_____

SECTION III - ACKNOWLEDGEMENT

I acknowledge the following:

☐ As certified by **my** health care provider, I have suffered a documented illness, accident or injury, that requires **my** absence from the workplace for a minimum of five consecutive workdays.

☐ I understand that all my accrued sick and annual leave and all types of earned compensatory leave must be exhausted before receiving benefits.

☐ I understand that I will receive benefits beginning with the sixth missed workday or partial workday or on the first day I exhausted all accrued leave, whichever is later.

☐ My illness, accident or injury is **NOT** the result of a workers' compensation claim for which I am receiving Workers' Compensation benefits or/and SES/SMS Disability Insurance.

SECTION IV - SIGNATURE

If you are/will be unable to communicate, you may designate a family member or friend, to act on your behalf. They will be responsible for ensuring required documents are submitted timely.

Name: _____

E-Mail: _____

Phone No.: _____

Employee Signature: _____ Date: _____

Caregiver Signature (if Employee unavailable): Date: