Selma City Schools
CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION FORM

Donating Employee Information

1. Employee Name:	
2. Social Security Number:	
3. Employee Address:	
4. Employee Telephone(s):	
5. Employer:	

Beneficiary Employee Information

6. Receiving Employee Name:	
7. Social Security Number:	
8. Beneficiary's Employer:	

Days to be Donated to Beneficiary (not to exceed 30 days)

9. Number of days to be donated:	

Certification of Donating Employee

10. I certify that I hereby donate the above noted number of my sick leave days to the beneficiary employee listed above. My employer has my permission to transfer the indicated number of sick leave days to the employer of the beneficiary for his/her use 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 specified number of days hereon and that the donated days will not be returned to me.

Donating employee's signature	
Date:	
Witness Signature	
Date	

Certification of Donating Employer

11. I hereby certify that the donating employee's information listed above is correct to the best of my knowledge.

Authorized signature	
Date	
Title	

Receipt of Beneficiary Employer

12. The above noted number of sick days has been credited to the sick leave account of the beneficiary employee. (Please give a copy of this form to the beneficiary employee.)

Authorized signature	
Title	
Date	

Print Clear