

WIRT COUNTY BOARD OF EDUCATION

LEAVE DONATION PROGRAM

APPLICATION TO RECEIVE DONATED LEAVE

**PART I - Applicant Information: To be completed by the applicant or designee.**  
**PLEASE PRINT OR TYPE**

1. Name: _____		2. Social Security Number: _____	
3. <b>WIRT COUNTY BOARD OF EDUCATION</b>		4. School/Location: _____	
5. _____		6. _____	
6. Work Phone: _____		7. Home Phone: _____	
8. Reason for Request: <input type="checkbox"/> Personal Medical Condition <input type="checkbox"/> Medical Condition of Immediate Family Member			
8a. Work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8b. Relationship: _____			
<p>The reason for the request <u>must</u> be verified by the physician or medical practitioner treating the individual with the medical condition. The physician or medical practitioner must provide all the information requested on the back of the form (PART III) and he/she must sign and date the form.</p>			
9. In applying for leave donations, I agree to have the following information published: my name, the agency I work for, the reason for my request, my last day at work, the date my leave available for this absence was or will be exhausted, and the expected duration of my absence.			
9a. Signature: _____		9c. Completed by: <input type="checkbox"/> Applicant	
9b. Date: _____		<input type="checkbox"/> Designee (specify): _____	
10. <b>OPTIONAL: TO BE COMPLETED ONLY BY THE APPLICANT.</b> As part of my application for leave donations, I further request that you also publish the following information regarding my medical emergency exactly as I have written it in the space below.			
10a. Signature: _____		10b. Date: _____	

**PART II – To be completed by the applicant’s Appointing Authority or Designee.**

1. Does the applicant receive annual and sick leave as a benefit or employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. For this absence, is the applicant receiving/eligible to receive Workers’ Compensation benefits, or is he/she receiving Social Security Disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. The applicant’s leave available for this absence was/will be exhausted on (date): _____	
4. The applicant, according to the information provided in <b>PART III</b> , is expected to be absent from work until (date): _____	
5. The leave of absence is: <input type="checkbox"/> Medical (Self) <input type="checkbox"/> Personal (Immediate Family)	
6. The applicant is: <input type="checkbox"/> <b>ELIGIBLE</b> to receive the leave donation.	
<input type="checkbox"/> <b>NOT ELIGIBLE</b> to receive the leave donation.	
6a. <b>REASON:</b> _____	
7. FIMS account information for recipient: _____	
8. Certified by: _____	9. Date: _____
10. Title: _____	11. Phone: _____

**QUESTIONS?**  
 Please call the person name in item 8.

