SICK LEAVE SHARING
Application

☐ ORIGINAL REQUEST
☐ AMENDED REQUEST

Name of Recipient:	
Agency Name:	
PERNR:	
Amount of Sick Leave Needed:	

Please provide a reason transferred leave is needed, including a brief description of the nature, severity, and anticipated duration of the medical emergency. (If this is an amended request, provide reason for extension.)

Please attach certification by one or more physicians of the medical reason that employee will be unable to perform the duties and responsibilities of his/her position for ten (10) or more consecutive working days or the reason for extension, if an amended request.

Signature of Recipient or Representative _____ Date _____

Signature of Supervisor _____ Date Received _____

The above named employee has been approved to receive donated sick leave in accordance with the provisions of KRS 18A.197.

Signature of Appointing Authority _____ Date _____

The Recipient's Appointing Authority must forward one copy of this form (without attached medical statement) to the Personnel Cabinet, Personnel Administration Branch, 501 High Street, 3rd Floor, Frankfort, Kentucky 40601.

SICK LEAVE SHARING
Donation Form

Name of Donor:	
Agency:	
PERNR:	
Amount of Donation to be credited to Recipient:	
(Employee must have 75 hours remaining after donation. Minimum amount employee may donate is 7.5 hours.)	
Name of Recipient:	
Agency:	
PERNR:	

I hereby certify that this donation is given without expectation or promise for any purpose other than that authorized by KRS 18A.197.

Signature of Donor _____ Date _____

This is to certify that the employee named above has a sufficient sick leave balance to donate the hours indicated under the provisions of KRS 18A.197.

Signature of Appointing Authority _____ Date _____

TO BE COMPLETED BY DONOR'S HR ADMINISTRATOR UPON RECEIPT	
The Donor's HR Administrator must forward one copy of this form to the Recipient's HR Administrator and one copy to the Personnel Cabinet, Personnel Administration Branch: 501 High Street, 3rd Floor, Frankfort, KY 40601.	
Agency Name:	
Donor HR Administrator:	
Date:	

TO BE COMPLETED BY RECIPIENT'S HR ADMINISTRATOR UPON RECEIPT	
Recipient's Current Sick Leave Balance= _____ + _____ donation = Recipient's New Sick Leave Balance	
Agency Name:	
Recipient HR Administrator:	
Date:	

PC/DHRA/DEM
March 2011