CLINTON COUNTY
LEAVE DONATION PROGRAM

Leave Donation Request Form

TO BE COMPLETED BY EMPLOYEE REQUESTING LEAVE DONATION

I, (print name) _____, hereby request donated leave to be used for a serious health condition for an immediate family member or my own health condition which renders me unable to perform the essential functions of my position. I understand that in order to receive donated leave, I must have exhausted my personal paid leave which includes sick leave, vacation, compensatory time, personal, and wellness (if applicable). I am also on an approved Family Medical Leave of which I do not have enough leave time to cover its duration. I realize once my 12 weeks of FML leave is up I can no longer receive leave donation(s)

Dates donated leave will be used:
From_____ To_____

If approved, I, hereby grant permission for Human Resources to release my name for the use of leave donations. I understand that this is a voluntary program and that county employees are not required to donate leave. I also understand that I will not be informed of the name of any donors or the number of hours individually donated.

_____ _____
Employee Signature Date

TO BE COMPLETED DEPARTMENT HEAD/ ELECTED OFFICIAL:

☐ Received/Notified

_____ _____
Signature Date

TO BE COMPLETED BY HUMAN RESOURCES:

☐ FMLA Medical Certification is currently on file OR
☐ FMLA Medical Certification is attached for review

☐ Approved OR
☐ Not Approved (reason(s))_____

_____ _____
Signature Date