The School Board of Nassau County, Florida

REQUEST FOR DONATION OF SICK LEAVE

Florida Statute: 1012.61 (2)(e)(2)
NTA Contract: XIV Leaves (A)(1)(g) • NESPA Contract: VI Leaves (A)(1)(c)

An employee of the District may receive donated sick leave from another employee (donor) for his/her own personal serious illness or injury. The recipient must have depleted his/her own sick leave prior to using any donated sick leave. The minimum number of days needed, verified by the medical physician, shall be five (5) days. Donated days shall not have terminal pay value. The identity of the donor(s) may not be made public.

Donation of sick leave is for the employee's own personal illness or injury.

Directions: Employees requesting donation(s) of sick leave must complete Section I and III. Section IV needs to be completed by the physician treating the serious illness or injury. The entire Request for Donation of Sick Leave packet is to be submitted directly to the Personnel Department. Employees requesting donation(s) of sick leave acknowledge that the information disclosed in Section III may be shared with the Principal/Director at his/her respective work location in an effort to generate donation(s) of sick leave.

SUBMIT THIS COMPLETED PACKET DIRECTLY TO THE PERSONNEL DEPARTMENT

SECTION I: TO BE COMPLETED BY THE EMPLOYEE

I have/will soon exhaust my sick leave and I am requesting a donation of sick leave from Nassau County School District employees who are eligible to donate sick leave time in accordance with the NTA/NESPA Contracts.

_____ _____
Print Name *Employee Id*

_____ _____
Signature *Date*

SECTION II: OFFICE USE ONLY

Approved:

_____ _____
Personnel Services *Date*

Approved:

_____ _____
Business Services *Date*

Routed to Principal/Director:

_____ _____
By Name *Date*

Routed to Business Services:

_____ _____
By Name *Date*

Nassau County School District Equity Statement

The Nassau County School District does not discriminate on the basis of race, color, national origin, gender, age, disability or marital status in its educational programs, services or activities, or in its hiring or employment practices. The district also provides equal access to its facilities to the Boy Scouts and other patriotic youth groups, as required by the Boys Scout of America Equal Access Act. Questions, complaints, or requests for additional information regarding discrimination or harassment may be sent to:
Equity Coordinator - Nassau County School District - 1201 Atlantic Ave., Fernandina Beach, FL 32034 Phone (904)491-9888 Fax (904)277-9044

SECTION III: EMPLOYEE STATEMENT

Please detail the nature of the illness or injury.

I acknowledge that the information contained within this Employee Statement may be shared with employees of the Nassau County School District by my Principal/Director in an effort to generate donation(s) of sick leave.

Printed Name

Employee Id

Signature

Date

SECTION IV: TO BE COMPLETED BY PHYSICIAN

1.) _____
Patient's Name

2.) Diagnosis:

_____

_____

_____

3.) Date Condition Commenced: _____

Probable Duration: _____

4.) Regimen of treatment to be prescribed (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week):

a.) By Physician: _____

_____

_____

b.) By another provider of Health Services, if referred by Physician: _____

_____

_____

PLEASE ANSWER ITEMS 5-8 AS IT RELATES TO THE EMPLOYEE:

	Yes	*No*	
5.)	( )	( )	Is inpatient hospitalization of the employee required?
6.)	( )	( )	Is employee able to perform work of any kind?
7.)	( )	( )	Will the employee require a minimum of five (5) days out of work (excluding weekends)?
8.)	( )	( )	Is employee able to perform the functions of the employee's position? (Answer after reviewing statement from employer describing the essential functions of the employee's position or, if none provided, after discussing with the employee.)

_____ _____

Typed Name of Physician | Signature of Physician

_____ _____

Date | Type of Practice (Field of Specialization, if any)