ATTACHMENT IV

HENRY COUNTY SICK LEAVE BANK

CATASTROPHIC SICK LEAVE DONATION FORM

DONATING EMPLOYEE INFORMATION:

Employee Name: _____

Employee Address: _____

Employee Telephone: _____

BENEFICIARY EMPLOYEE INFORMATION:

Receiving Employee Name: _____

DAYS TO BE DONATED TO BENEFICIARY (not to exceed 30 days):

Number of days to be donated: _____

CERTIFICATION OF DONATING EMPLOYEE:

I certify that I hereby donate the above noted number of my sick leave days to the beneficiary employee named above. 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.

WITNESS: DONATING EMPLOYEE'S SIGNATURE:

_____ _____

DATE: _____