ATTACHMENT VI

CATASTROPHIC SICK LEAVE DONATION AUTHORIZATION

(OUTSIDE OF HENRY COUNTY SICK LEAVE BANK)

DONATING EMPLOYEE INFORMATION

1. Employee Name:
2. Employee Address:
3. Employee Telephone(s):
4. Employer:

BENEFICIARY EMPLOYEE INFORMATION

5. Receiving Employee Name:
6. Beneficiary's Employer:

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

7. Number of days to be donated:

CERTIFICATION OF DONATING EMPLOYEE

8. I certify that I hereby donate the above noted number of my sick leave days to the beneficiary employee listed above. My employer has my permission to transfer the indicated number of sick leave days to the employer of the beneficiary for his or her use due to a catastrophic illness/injury as defined by Act 93-753. 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.

Donating employee's signature: _____ Date: _____

Witness: _____ Date: _____

CERTIFICATION OF DONATING EMPLOYER

9. I hereby certify that the donating employee's information listed above is correct to the best of my knowledge.

Authorized Signature:_____ Date: _____
Title:_____

RECEIPT OF BENEFICIARY EMPLOYER

10. The above noted number of sick leave days has been credited to the sick leave account of the beneficiary employee.

Authorized Signature: _____ Date: _____
Title:_____