

**EMPLOYEE REQUEST FOR DONATED SICK LEAVE
EACC/AFSCME**

RECIPIENT'S NAME _____ EMPLOYEE ID# _____

LOCATION _____ POSITION _____

DATE OF REQUEST _____

THIS IS _____ AN ORIGINAL REQUEST
_____ A MODIFICATION TO AN EARLIER
REQUEST

EXPECTED DATES OF ABSENCE _____

CONDITION NECESSITATING ABSENCE _____
(DOCUMENTATION MUST BE PRESENTED BY PHYSICIAN)

DATE RECIPIENT'S OWN LEAVE WILL BE DEPLETED _____

DATE ELIGIBLE TO USE DONATED LEAVE _____

SIGN AND DATE REVIEWED BY EACC OR AFSCME (Please circle)

SIGN AND DATE APPROVED BY HUMAN RESOURCES CCPS

Classified Employees fax form to Human Resources at 301-934-7235.

Certificated Employees fax form to EACC at 301-392-0151.