



# CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION

**DONOR NAME**

**JOB TITLE**

**EMPLOYEE ID NUMBER** *(Kelly Services PIN)*

**WORK SITE**

I wish to be a member of the Dothan City Schools Sick Leave Bank and hereby authorize that **five (5) days** from my personal sick leave be placed in the bank. I have received a copy of the Guidelines for the Dothan City Schools Sick Leave Bank Board and hereby agree to comply with the guidelines as printed.

I do not have the accumulated sick leave necessary to join the Sick Leave Bank. However, as soon as I do have the designated number of days, I wish to become a participating member and have those days placed in the bank.

I do not wish to be a member of the Sick Leave Bank at this time.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date