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|  | **State of Florida****INTERAGENCY SICK LEAVE TRANSFER****REQUEST TO DONATE** |

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| **Part I - Request to Donate Sick Leave Hours - Donor Information** |
| *I certify that I have read and understand the requirements and provisions of Rule 60L-34.0042(5), F.A.C., and that I am eligible and willing to donate my personal sick leave credits as specified below. I further understand that the donated sick leave credits will be* ***permanently*** *deducted from my sick leave balance at the end of the pay period and if unused, will be returned.* |
| Print Name:       | People First Employee ID#:       |
| Agency/Division/Bureau or District/Region/Institution:       |
| Work Telephone Number: (     )       |  |
| I authorize my employer to transfer       hours of sick leave to the following recipient (minimum of 8 hours). |
| [ ]  *I certify that I am related to the recipient by birth, marriage or other legal relationship, as specified in Rule 60L-34.0042(5)(b), F.A.C., (spouse, parents, grandparents, brothers, sisters, children and grandchildren of either the employee or the spouse).*  |
| Signature |  | Date |
| **RECIPIENT INFORMATION** |
| Recipient's Name:       |  People First Employee ID# (if known):       |
| Agency/Division/Bureau or District/Region/Institution:        |
|  |
| **Part II - For Personnel Office(s) Use** |
| **Recipient's Agency** | **Donor's Agency** |
| Date:   /  /     | Date:   /  /     |
| **Send To:** Sick Leave Transfer (SLT) Plan Administrator Personnel Office/Human Resources | **Send To:** SLT Plan Administrator  Personnel Office/Human Resources |
| Department of       | Department of       |
| Telephone:       | Fax:       | Telephone:       |  |
| Hours Credited:       | PPE:   /  /     | Fax:       |  |
| Hours Credited:       | PPE:   /  /     | Hours Charged:       | PPE:   /  /     |
| Hours Credited:       | PPE:   /  /     | [ ]  Approved | [ ]  Disapproved  |
| Hours Credited:       | PPE:   /  /     | SLT Administrator's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Approved Per Criteria | [ ]  Disapproved Per Criteria | Print SLT Administrator's Name:       |
| SLT Administrator's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **To return unused sick leave to the donor,****complete Part III of this form.** |
| Print SLT Administrator’s Name:       |

**DMS-SLDONATIONTEMPLATE Rev. 10/15**

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| **Part III - Return of Unused Sick Leave Hours** |
| **To:** |  |  |
|  | Agency      |  |
|  | Sick Leave Transfer Plan Administrator      |  |
|  | Address |  |
| **From:** |  |  |
|  | Agency      |  |
|  | Sick Leave Transfer Plan Administrator |  |
|  | Signature |  |
| **Please credit** **hours back to:** |       |
|  | Employee Name |
| **People First Employee ID#:**  |