



Detroit Public Schools Office of Payroll

AUTHORIZATION TO DONATE SICK LEAVE DAYS

(Pursuant to the Detroit Public Schools and Detroit Federation of Teachers ("DFT") Sick Leave Donation Policy)

Employee: _____ Date: _____

Employee ID No.: _____ Work Location: _____

I wish to donate _____ sick day(s) from my accrued sick leave bank to my fellow DFT member.

Name of Employee to Receive Donated Day(s): _____

Work Location of Employee to Receive Donated Days: _____

I understand that:

- My total accrued sick leave bank balance will be reduced by the number of sick day(s) donated to my fellow DFT member, as stated above.
- I cannot revoke or cancel my request to transfer donated day(s).
- I cannot utilize my catastrophe bank to donate day(s).
- Donated day(s) are irrevocable and will not be returned to me.

I acknowledge that I have read and understand all statements referenced above regarding the authorization to donate sick days. I certify I am the person named above and this consent is given freely based on true and accurate data and that I may be subject to disciplinary action, up to and including termination, for false misrepresentation.

Employee's Signature (Donor)

Date

ID No. (Driver's License or State ID)

PLEASE DO NOT WRITE BELOW THIS LINE

Leave Bank Transfer Approved by Payroll Audit Supervisor: _____

| Donor's Beginning Sick Leave Bank Balance (Before Transfer) | Number of Day(s) Transferred | Donor's Remaining Sick Leave Bank Balance (After Transfer) | Effective Pay Period of Transfer | Name of Recipient of Donated Sick Day(s) |
|---|------------------------------|--|----------------------------------|--|
| | | | | |

COMMENTS: _____ Maximum Days Exceeded / _____ Days Not Accrued

Leave Bank Transfer Completed by Payroll Auditor: _____

Date of Transfer: _____