**Newark Public School District**

**Sick Day Donor Program Request Form**

**DATE RECEIVED BY DIV. OF HEALTH EDUCATION AND SERVICE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PART I - TO BE COMPLETED BY DONOR**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SSN#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POSTION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **LOCATION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **LOC. #** \_\_\_\_\_

**I HAVE AGREED TO DONATE \_\_\_\_\_ SICK DAYS TO THE EMPLOYEE NAMED BELOW. I UNDERSTAND THAT UNDER NO CIRCUMSTANCES WILL I BE ABLE TO RETRIEVE THE DAYS I HAVE DONATED.**

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART II – TO BE COMPLETED BY RECIPIENT**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POSITION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **LOCATION:** \_\_\_\_\_\_\_\_\_\_\_ **LOC. #** \_\_\_\_\_

**I UNDERSTAND THAT I WILL USE THE \_\_\_\_\_\_ DONATED DAYS FOR MY EXTENDED ILLNESS AND I WILL NOT BE ABLE TO REDEEM THESE DAYS IN THE FORM OF BUYBACK OR TERMINAL LEAVE. THE ILLNESS FOR WHICH THIS REQUEST IS MADE IS INDICATED WITHIN THE ATTACHED DOCUMENTATION.**

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART III – TO BE COMPLETED BY OFFICE OF HEALTH EDUCATION AND SERVICE**

**THE MEDICAL CERTIFICATE FOR THE ABOVE RECIPIENT HAS BEEN.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **APPROVED**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **DATE ILLNESS BEGAN** **RETURN TO WORK DATE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DISAPPROVED** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **SIGNATURE OF BOARD PHYSICIAN DATE**

**PART IV – TO BE COMPLETED BY OFFICE OF PAYROLL**

**NUMBER OF DAYS TO BE CREDITED:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE REFLECTED ON TIME REPORT DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AMOUNT REIMBURSED/DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE PAID ON CHECK DATED:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROCESSED BY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_