Newark Board of Education
Sick Day Donor Program Request Form

DATE RECEIVED BY DEPARTMENT OF HEALTH SERVICES:

PART I - TO BE COMPLETED BY DONOR

NAME: _____ **EMPLOYEE ID #:** _____

ADDRESS: _____

POSITION: _____ **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: _____ **EMPLOYEE ID #:** _____

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 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: _____