EMPLOYEE REQUEST FOR DONATED SICK LEAVE
EACC/AFSCME

RECIPIENT'S NAME_____ EMPLOYEE ID#_____

LOCATION_____ POSITION_____

DATE OF REQUEST_____

THIS IS _____ AN ORIGINAL REQUEST

_____ A MODIFICATION TO AN EARLIER REQUEST

EXPECTED DATES OF ABSENCE_____

CONDITION NECESSITATING ABSENCE_____
(DOCUMENTATION MUST BE PRESENTED BY PHYSICIAN)

DATE RECEPIENT'S OWN LEAVE WILL BE DEPLETED_____

DATE ELIGIBLE TO USE DONATED LEAVE_____

_____ REVIEWED BY EACC OR AFSCME (Please circle)
SIGN AND DATE

_____ APPROVED BY HUMAN RESOURCES CCPS
SIGN AND DATE

Classified Employees fax form to Human Resources at 301-934-7235.
Certificated Employees fax form to EACC at 301-392-0151.