

MADISON COUNTY SCHOOLS

CATASTROPHIC SICK LEAVE TRANSFER AUTHORIZATION

(Please type or print legibly)

BENEFICIARY NAME: _____

POSITION: _____

SCHOOL/WORK SITE: _____

DONOR NAME: _____

EMPLOYEE NUMBER: _____ **POSITION:** _____

SCHOOL/WORK SITE: _____

I authorize the transfer of _____ sick leave days from my accumulated sick leave to the
(Number of days)
beneficiary named above. I understand these days will not be returned to me unless beneficiary
does not use them.

DONOR'S SIGNATURE

DATE

Donor's Employer Authorization

I certify the donor named above has sufficient sick leave days to donate the number of days indicated.

DONOR'S EMPLOYER AUTHORIZED SIGNATURE

DATE

Approved: Nov 1993
Revised: Feb 2000
Revised: Feb 2001

MADISON COUNTY BOARD OF EDUCATION