STATE OF TENNESSEE
DEPARTMENT OF HUMAN RESOURCES
TECHNICAL SERVICES DIVISION
SECOND FLOOR, JAMES K. POLK BUILDING
505 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-0635
TEL: (615) 741-5595 FAX: (615) 401-7685

REQUEST FOR DONATED SICK LEAVE

Please complete and submit this Request for Donated Sick Leave through your human resources office.

Employee's Name: Last _____ First _____ Home Phone # (_____)_____

Employee's ID Number: _____ DOB: _____ _____ _____

Home Address: _____ City _____ State _____ Zip _____

Employee's Department and Position Title: _____

1) Have you applied for Social Security disability? Yes ____ No ____ Date applied: _____

2) Are you currently approved for or receiving Social Security disability? Yes ____ No ____If yes, effective date: _____

3) Have you applied for retirement through the Tennessee Consolidated Retirement System?.....Yes ____ No ____

4) Are you currently earning and/or receiving income from other employment? (excluding pensions) ..Yes ____ No ____

I provided my medical doctor/surgeon with a Medical Statement for the Transfer of Donated Sick Leave form to confirm my illness or injury as required by the Transferring Sick Leave Between State Employees procedures as outlined in the Attendance and Leave Manual of the Department Human Resources. I instructed my medical doctor/surgeon to send the completed form directly to the Technical Services Division at the address listed at the top of the form. I understand that authorization for the transfer of sick leave is subject to approval by the Technical Services Division and the availability of donated sick leave. Authorization for the transfer of sick leave shall not exceed more than thirty (30) consecutive days per application.

I understand that authorization for the transfer of sick leave shall not exceed ninety (90) days within a twelve (12) month period. In addition, the maximum number of donated sick leave days that an employee may receive during his or her state employment is 120 days. I understand that sick leave may not be transferred retroactively beyond one (1) pay period.

I certify that the information given in this request is correct and complete to the best of my knowledge. I am aware that should investigation show any material misrepresentation of facts, I will not be considered for donated sick leave and I may be subject to disciplinary action up to and including dismissal. I hereby authorize the Technical Services Division of the Department of Human Resources to make all necessary investigations concerning this application. I further authorize and request any records or information, including but not limited to medical, state retirement or social security disability, that is sought in connection with this request be provided to the Technical Services Division.

_____ _____

Signature of Employee or Legal Representative and Date

Signature of Human Resources Officer and Date