APPLICATION FOR DONATION OF LEAVE FOR CATASTROPHIC ILLNESS

FAX: (251) 470-1708

Note: According to Rule III, **a catastrophic illness** or **injury** is defined as one in which full recovery is not expected or in which an extensive period of not less than (4) weeks of recuperation is anticipated. All accrued annual leave, sick leave and compensatory time of the Donee must be completely exhausted before the Donee is entitled to any donated leave. **Please attach doctor's certificate**.

SSN #_____ **Compensatory Time Balance**: _____
(Last Four Digits Only)

Legal Name: _____
(*Same Name as on Social Security Card*) Last First Middle Maiden

Address:_____
Street City State Zip

Phone:_____
Office Home Cell

Jurisdiction: _____ **Department:** _____

Class Desc: _____ **Current Rate of Pay**: _____

Having been classified as having a catastrophic illness or injury and having exhausted all of my accumulated leave (Vacation, Sick, and Compensatory Time) I hereby make application for the use of any donated leave available to me.

_____ _____
Employee Signature (or Authorized Family Member)* **Date**

*If family member, print name and indicate relationship: _____

_____ _____
Appointing Authority Signature **Date**

Effective Date for Leave to Begin: _____

FOR MOBILE COUNTY PERSONNEL BOARD USE ONLY

Approved ☐ Denied ☐ Forwarded to Accounting:_____
Date

_____ _____
Personnel Director's / Asst. Director's Signature Date of Approval