CATASTROPHIC LEAVE TRANSFER AUTHORIZATION

DONATING EMPLOYEE INFORMATION

Employee Name _____ **SSN #** _____
(*Last, First, MI*) (*Last Four Digits Only*)

Employee Address _____ **City** _____ **State** _____ **Zip** _____

Jurisdiction _____

Employee Class Desc _____ **Department** _____

Maximum Donation of 240 hours to be used January - December in 1-hour increments

Number of hours to be donated: (Sick) Hours ☐ **(Vacation) Hours** ☐

CERTIFYING OF DONATING EMPLOYEE

I certify that I hereby donate the above noted number of hours leave to the beneficiary employee listed above. My employer and the Personnel Board have my permission to transfer the indicated number of hours leave to the employer of the beneficiary for his or her use for a catastrophic illness. It is my understanding that my leave balance will be reduced by the specified number of hours hereon as used by the beneficiary employee and that the donated hours will not be returned to me.

Donating Employee's Signature: _____ **Date**: _____

Witness: _____ **Date:** _____

RECEIVING/BENEFICIARY EMPLOYEE INFORMATION

Employee Name _____ **SSN #**_____
(*Last, First, MI*) (*Last Four Digits Only*)

Employee Class Desc _____ **Department** _____

CERTIFICATION OF DONATING EMPLOYER

I hereby certify that the donating employee's information listed above is correct to the best of my knowledge.

Authorized Signature: _____ **Date:** _____

Title: _____
Appointing Authority or Department Head

FOR MOBILE COUNTY PERSONNEL BOARD USE ONLY

Donor's Rate of Pay $_____ / hour **Receiver's Rate of Pay** $_____ / hour

_____ x $_____ / hour = $_____ Divided by $_____ / hour = _____
Donated Hours Donor's Rate Value of Donation Receiver's Rate Hours Received

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

Office Use Only

PB Form 3.11-B July 2021