CATASTROPHIC LEAVE TRANSFER AUTHORIZATION

DONATING EMPLOYEE INFORMATION

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

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

Jurisdiction _____

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

I certify that I hereby donate the above noted number of hours leave to the beneficiary employee listed above.

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

RECEIVING/BENEFICIARY EMPLOYEE INFORMATION

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

CERTIFICATION OF DONATING EMPLOYER

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

Signature: _____ **Date:** _____

Title: _____
Appointing Authority or Department Head

FOR MOBILE CIVIL SERVICE 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

_____ _____
Civil Service Director's / Deputy Civil Service Director's Signature Date of Approval