SHARED SICK LEAVE PROGRAM

SHARED SICK LEAVE REQUEST FORM
Recipient Affidavit

I request a sick leave award from the Shared Sick Leave Program under the terms specified in the Dalton State program description, with the understanding that the specific nature of my illness will be kept confidential.

_____ _____
Name of Recipient (employee) ADP Employee ID

_____ _____ @daltonstate.edu
Department/Division/School E-mail

Request shared sick time to begin _____ and end on _____.
Date Date

I have not directly or indirectly solicited donations of sick leave from other Dalton State employees independently. I have not interfered with any right which another employee may have with respect to contributing, receiving, or using sick leave under this program.

I have submitted a Physician's Certification Form which confirms a life-threatening or emergency medical condition as described in the Dalton State Shared Sick Leave Program.

I certify that the above statements are true and complete to the best of my knowledge. If I am acting on behalf of the employee recipient, I am providing documentation as having Power of Attorney this this form.

_____ _____
Signature of Recipient or Recipient's Authorized Representative Date

INSTRUCTIONS: Please forward this completed Recipient Affidavit, completed Physician's Certification Form, Power of Attorney if applicable, and any other supporting documentation to Dalton State College, Office of Human Resources, 650 College Drive, Dalton, GA 30720. Please mark CONFIDENTIAL.