Escambia County Board of County Commissioners
Annual Leave Donation
Recipient Application

Name: _____ **Employee No:** _____

Job Classification: _____ **Department:** _____

This is to request _____ hours from the Annual Leave Donation Program.

I certify that I meet all eligibility requirements of this policy. Certification of illness, accident, or injury from my physician, _____ has been provided to my Department along with
Physician Name
a completed HIPPA Authorization Form and a written statement indicating what I authorize to be released on the County's Intranet website.

In addition, I hereby authorize the Sick/Annual Leave Donation Coordinator to seek additional information from my phyician(s) as may be necessary.

_____ _____
Employee Signature Date

DEPARTMENT CERTIFICATION

Date Absence Began: _____

Doctor's Certificate Attached: ☐
Employee's Statement Attached: ☐
HIPPA Authorization Attached: ☐

Hours Used within last 12 months:

_____ **Annual Leave**	_____ **Sick Leave/ELB**	_____ **MOB**
_____ **LWOP**	_____ **Compensatory**	_____ **Sick Leave Pool**

Current leave balances when application submitted:

_____ **Annual Leave**	_____ **Sick Leave/ELB**	_____ **MOB**
_____ **LWOP**	_____ **Compensatory**	_____ **Sick Leave Pool**

We, the undersigned, validate that the above employee has exhausted all paid leave, including compensatory leave; and is not on Worker's Compensation.

_____ _____
Department Recordkeeper Signature Date

Acknowledgment:

_____ _____
Department Head/Division Manager Signature Date

Copy: Department

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