APPLICATION TO REQUEST SICK LEAVE DONATION

RECIPIENT'S NAME (Must have @ least
Two (2) years of experience @ NF): ______________________________

DATE REQUESTED: ______________________________

NAME OF PERSON WHO HAS
CATASTROPHIC ILLNESS OR INJURY: ______________________________

RELATIONSHIP TO RECIPIENT? (Circle one) SELF SPOUSE CHILD(REN)

ARE YOU, YOUR SPOUSE, AND/OR YOUR CHILD(REN) CURRENTLY UNDER A PHYSICIAN'S CARE?

YES (Please attach a notice of estimated date of return from your physician) OR NO

OF DAYS REQUESTING
(Thirty {30} days maximum per school year): ___________________________

I understand this application will be reviewed by the Sick Leave Donation Committee and their decisions are final.

____ ____________________
Recipient's Signature (Must be Legible) Date

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Office Use Only: # of requested donation days approved: ____________ Day(s)

____ ____________________
Superintendent's Signature (Must be Legible) Date

____ ____________________
Treasurer's Signature (Must be Legible) Date

____ ____________________
NFEA President's Signature (Must be Legible) Date

____ ____________________
OAPSE President's Signature (Must be Legible) Date