State of Florida

INTERAGENCY SICK LEAVE TRANSFER

REQUEST TO DONATE

Part I - Request to Donate Sick Leave Hours - Donor Information

I certify that I have read and understand the requirements and provisions of 60L-34.0042(5), F.A.C., and that I am eligible and willing to donate my personal sick leave credits as specified below. I further understand that the donated sick leave credits will be ***permanently*** *deducted from my sick leave balance at the end of the pay period and if unused, will be returned.*

Print Name: _____ People First Employee ID#: _____

Agency/Division/Bureau or District/Region/Institution: _____

Work Telephone Number: (___) _____

I authorize my employer to transfer _____ hours of sick leave to the following recipient (minimum of 8 hours).

☐ *I certify that I am related to the recipient by birth, marriage or other legal relationship, as specified in 60L-34.0042(5)(b), F.A.C., (spouse, parents, grandparents, brothers, sisters, children and grandchildren of either the employee or the spouse).*

Signature _______________ Date _______________

RECIPIENT INFORMATION

Recipient's Name: _____ Class Title (if known): _____

Agency/Division/Bureau or District/Region/Institution: _____

People First Employee ID # (if known): _____

Part II - For Personnel Office(s) Use

Recipient's Agency

Date: __/__/____

Send To:
Sick Leave Transfer (SLT) Plan Administrator (SLT)
Personnel Office/Human Resources

Department of _____

Telephone: _____

Fax: _____

Hours Credited: _____ PPE: __/__/____

Hours Credited: _____ PPE: __/__/____

Hours Credited: _____ PPE: __/__/____

☐ Approved Per Criteria ☐ Disapproved Per Criteria

SLT Administrator's Signature: ______________________

Print SLT Administrator Name: _____

Donor's Agency

Date: __/__/____

Send To:
Sick Leave Transfer (SLT) Plan Administrator
Personnel Office/Human Resources

Department of _____

Telephone: _____

Fax: _____

Hours Charged: _____ PPE: __/__/____

☐ Approved ☐ Disapproved

SLT Administrator's Signature: ______________________

Print SLT Administrator's Name: _____

To send unused sick leave back to donor, complete the reverse side of this form.

Part III - Return of Unused Sick Leave Hours

To:

____
Agency

____
Sick Leave Transfer Plan Administrator

____
Address

From:

____
Agency

____
Sick Leave Transfer Plan Administrator

____
Signature

Please credit _____ hours back to: ____
Employee Name

People First Employee ID#: _____

Return to the Bureau of Human Resources, Attendance & Leave, 2737 Centerview Drive, Tallahassee, Florida 32399-3100