



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 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 physician(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