REQUEST FOR LEAVE SHARING
OKLAHOMA COUNTY

PART I.   DONOR

_____   _____   _____
Employee Name   Social Security Number   Department

_____
Job Title

A.   DONOR REQUEST
Approval is requested to donate ___ (total number of hours wanting to donate). By signing this section, I hereby certify that this request is being made voluntarily. I was not coerced, threatened, intimidated, or financially induced into donating annual leave for purposes of the leave sharing program.

_____   _____
Employee   Date

B.   DONOR ELIGIBILITY VERIFICATION:
Employee's Annual Leave Balance _____ Hours as of _____   Hourly rate _____

_____   _____
Signature of Immediate Supervisor   Date

C.   APPROVAL/DISAPPROVAL:
_____ Disapproved   Reason Disapproved: _____
_____ Approved

_____   _____
Signature of County Officer or Director   Date

PART II: RECIPIENT

_____   _____   _____
Employee Name   Social Security Number   Department

_____
Job Title

A.   RECIPIENT REQUEST:
I would like to be considered to receive donated leave as authorized by County Policy.

I hereby certify that this request is because I am suffering from, or my relative or household member is suffering from an extraordinary or severe: illness, injury, impairment, or physical or mental condition which has caused or is likely to cause me to take leave without pay or terminate employment.

I have exhausted or will exhaust all annual leave and sick leave.

I have not received the maximum of two hundred sixty-one (261) days of shared leave during my total county employment.

By signing this section, in addition to the above, I also certify that I have not coerced, threatened, intimidated or financially induced anyone into donating annual leave for purposes of the leave sharing program. I understand having done so could result in termination of my employment.

_____   _____
Signature of Employee   Date

B.   MEDICAL STATEMENT:
A medical certification from a licensed physician or health care provider verifying the severe or extraordinary nature and expected duration of the condition must be attached to this form.
Attached: _____ yes   _____ no

C.   ELIGIBILITY VERIFICATION:
Employee's Annual Leave Balance _____ Hours as of _____   Hourly rate $_____

_____   _____
Signature of Immediate Supervisor   Date

D.   APPROVAL/DISAPPROVAL:
_____ Disapproved   Reason Disapproved:_____
_____ Approved

_____   _____
Signature of County Officer or Director   Date

- -

PART III: CALCULATION OF HOURS

Donor Rate	Recipient Rate	Conversion Factor	Donated Hours	Hours Received	Date Transferred
_____ /	_____ =	_____	x _____	= _____	_____

Human Resource/Payroll verification:

_____   _____   _____   _____
Signature of Donor's Department   Date   Signature of Recipient's Department   Date