Franklin County
Where Government Works

LEAVE DONATION PROGRAM – APPLICATION FORM

NAME (PRINT) LAST	FIRST	MIDDLE INITIAL	DATE:

EMPLOYING AGENCY:

_____

I REQUEST LEAVE BEGINNING_____A.M. _____, _____, 20___ AND
P.M.

ENDING_____A.M._____, _____, 20___ FOR
P.M.

THE FOLLOWING REASON:

CHECK ONE:

___ SERIOUS PERSONAL ILLNESS OR INJURY _____

___ SERIOUS ILLNESS OR INJURY IN IMMEDIATE FAMILY _____

If my application for the leave donation program is approved, I hereby give permission for the agency director and other agency management to inform my coworkers of my critical need for leave.

_____
SIGNATURE OF EMPLOYEE

OR

_____
SIGNATURE OF IMMEDIATE FAMILY MEMBER (IF APPLICABLE)

FAMILY OR MEDICAL LEAVE

___ Please check here if any of the above requests for leave are for a family or medical leave (FMLA) per the policy in the employee handbook or union contract, where applicable.

If so, please attach the required documentation.

ADMINISTRATIVE ACTION:

____ Approved ____ Approved
____ Disapproved ____ Disapproved

_____ _____
AGENCY DIRECTOR DATE HR DIRECTOR DATE

REMARKS: _____

_____

MAXIMUM TOTAL LEAVE DONATION HOURS APPROVED _____