 Form GARH-5

**EMPLOYEE DONATING SICK LEAVE**

**TO A SPOUSE EMPLOYED BY DISTRICT**

For the purposes of maternity leave, personal illness, illness of a family member, or death of a family member, a District employee may donate up to ten sick leave days to his or her spouse if the spouse is also an employee of the District. Additional requirements also apply:

* Both District employees must be a member of the District Catastrophic Leave bank(CILB)
* One spouse must have exhausted all available short term leave before being eligible to receive the sick leave donation from his or her spouse
* Employees must be able to provide medical certification of illness/death, if requested

**Spouse #1**- **Requesting Sick Leave Donation:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name: |  |  | SS#: xxx-xx- |  |  | Work Site: |  |

(Please print)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Work Phone Number: |  |  | Home Phone Number: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Email Address: |  |  | Member of CILB? | Yes No |

|  |  |
| --- | --- |
| Number of Sick Leave Days Requested from Spouse (no more than 10): |  |

|  |  |
| --- | --- |
| Date donation begins: |  |

**Purpose (check one):**

Maternity

Personal Illness

Illness of a family member

Death of a family member

Employee’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse #2- Donating Sick Leave:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name: |  |  | SS#: xxx-xx- |  |  | Work Site: |  |

(Please print)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Work Phone Number: |  |  | Cell Phone Number: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Email Address: |  |  | Member of CILB? | Yes No |

Employee’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Home Mailing Address: |  | | | | | | |
| City: |  |  | State: |  |  | Zip: |  |

**PLEASE FAX THIS FORM TO:**

**BENEFITS MANAGER (678) 594-8580**