FLORIDA DEPARTMENT OF JUVENILE JUSTICE
DJJ SICK LEAVE DONATION/ TRANSFER REQUEST TO USE FORM

Part I – Request to Use Donated Sick Leave

I certify that I have suffered an accident, childbirth, illness, or injury. I understand that I must exhaust all of my personal leave credits, with the exception of my personal holiday; to request to use donated sick leave credits to cover my absences. I understand that it is my responsibility to read and adhere to the Sick Leave Donation/Transfer Policy and Procedure. I will ensure that the Bureau of Human Resources receive all required documents necessary to approve my request, two (2) business days prior to payroll deadline. In the event of an untimely notification of return to work, I may receive a salary overpayment letter and will be required to repay sick leave credits I was not entitled. I understand that I may solicit sick leave donations from co-workers, family and friends within DJJ, as well as from other agencies that participate in the Sick Leave Donation/Transfer Plan.

I authorize my employer to use my name and release a general description of the medical circumstances in order to determine my eligibility in accessing this benefit.

Date Absence Began or Will Begin: _____/_____/_____ Signed: _____ Date: _____/_____/_____

Signer must check where applicable: ☐ Self ☐ Spouse ☐ Other authorized person representing employee

Part II – Medical Documentation

THE FOLLOWING IS CONFIDENTIAL MEDICAL INFORMATION

Based on my current accident, childbirth, illness, or injury, I am applying for donated sick leave credits from my employer's Sick Leave Donation/Transfer Plan. I hereby authorize any healthcare practitioner who has examined me with respect to my current accident, childbirth, illness, or injury, to complete and answer any relevant questions that may be asked by the Sick Leave Donation/Transfer Plan Coordinator in order to determine my eligibility for this benefit.

Employee's Signature: _____ Date: _____/_____/_____

Employee's Name **(Print)**: _____ People First User ID#: _____

Supervisor's Signature: _____ Date: _____/_____/_____

Part III - To Be Completed by Treating Healthcare Provider Only

Print Healthcare Provider's Name: _____ Business Telephone: ( ) _____

Mailing Address: _____

Date of which patient was first examined for current condition: _____/_____/_____

Patient's condition is due to: ☐ Accident ☐ Childbirth ☐ Illness ☐ Injury **(please check one)**

Date patient is expected to recover or be released to duty: _____/_____/_____ Check one: ☐ Part-time ☐ Full-time

If part-time, what are the following restrictions: _____

Signature of treating healthcare provider: _____ State/License Number: _____

Return this form (marked confidential) to the Department of Juvenile Justice, Bureau of Human Resources, 2737 Centerview Drive, Tallahassee, Florida 32399-3100 or you may fax to 850-921-6700.

INSTRUCTIONS FOR AUTHORIZED USE OF THIS FORM: In order for the patient to comply with the eligibility requirements, the treating healthcare provider must complete this form and return it to the patient's employer directly or the patient.

Save As.. Print Clear Form