

**COMANCHE INDEPENDENT SCHOOL DISTRICT
CATASTROPHIC SICK LEAVE POOL
EMPLOYEE DONATION AUTHORIZATION FORM**

Name: _____ Date: _____

Position/Assignment: _____ School/Department _____

Employed by Comanche ISD since _____ (date)

Number of Local Leave Days Accumulated _____

Number of Days I Wish to Donate _____ (no less than ½ day, no more than 5 days)

I have read and understand the Comanche ISD Sick Leave Pool Procedures. I further understand and agree as follows:

1. My donation to the Comanche ISD Sick Leave Pool is strictly voluntary, and I have not been coerced or otherwise pressured by any District employee or administrator to make this donation. My donation is not a condition of my employment with Comanche ISD.
2. I am eligible to receive local sick leave benefits from Comanche ISD, and have accumulated no less than the number of local sick leave days I request to donate to the Sick Leave Pool.
3. My donated days will be subtracted from my local sick leave record.
4. My donated days become the property of the Comanche ISD Sick Leave Pool, and may only be returned to me as provided in the Sick Leave Pool Procedures.
5. In the event days are eligible to be returned to me, I understand that may only receive a pro rata share of those days remaining, and in no event will the number of days returned be in excess of what I donated.
6. I have not been provided any personal or medical information regarding the Comanche ISD employee requesting leave from the Sick Leave Pool.

I certify that the information provided in this request is true and correct.

Signature

Date

FOR SCHOOL USE ONLY

Date Received: _____

Date Donation Request Granted: _____ **OR** Denied: _____

Date Employee Notified: _____