

Hillsboro Classified United #4671
SICK LEAVE DONATION REQUEST FORM

Name: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Work Site: _____ Job Class: _____ Contracted Daily Hours: _____

Date of first day of sick leave: _____ Number of days requested: _____

Anticipated date of return to work: _____ Actual date of return to work: _____

You must submit with this request form:

1. **Personal statement indicating the circumstances for which you are requesting a sick leave donation.**
2. **Medical evaluation form completed by your physician confirming you are unable to perform your assigned job duties due to long term illness or injury.**
3. **Have you used:**
 - a. **All individual accumulated paid sick leave** Yes _____ No _____
 - b. **All individual vacation days** Yes _____ No _____
4. **Have you applies for Long Term Disability** Yes _____ No _____

By signing this form:

- I understand that I must refund any sick leave that I was paid from donations and concurrently received income from Long Term Insurance, Worker's Compensation, or PERS Disability.
- I authorize the HCU Executive Council to verify my date of employment, paid sick leave, vacation and comp time balances.
- I affirm that the information I have provided is accurate to the best of my knowledge.

Signature _____ Date _____

Please send this request form to:

Chris Collings, 2nd VP at HCU via inner-office mail

Or by postmark to: HCU, 245 SE 4th Avenue STE A, Hillsboro, OR 97123

Requests will be reviewed by the HCU Executive Council and you will be notified of their decision.

Request Tracking Section (Do Not Fill Out)

Received (Date) _____ Reviewed (Date) _____ Approved _____ Denied _____

Employee Notified (Date) _____ HCU Board Member Signature _____