



HIDALGO COUNTY

REQUEST FOR SICK LEAVE DONOR PROGRAM FORM

Name of Employee: _____ SSN: _____
Department: _____ Job Title: _____
Date of Request: _____ Number of days requested: _____
Date of Employment: _____ Employee # _____

Accumulated Leave (Hrs): A/L _____ S/L _____ C/T _____

Department Head/Supervisor

Date

I have (or will have) used all my available paid leave days for this calendar year.

- Do you anticipate any additional days to be needed for follow-up examination treatment?
Yes _____ No _____
- Have you made claim or are you entitled to Worker's Compensation Benefits?
Yes _____ No _____

The above requested days are needed for the reason of personal illness as described in the attached by my physician on the: Health Care Provider Certification.

Name of Physician (s): _____
Address of Physician (s): _____
Phone Number (s) of Physician (s) _____

I hereby verify that the information given is valid to the best of my knowledge and I authorize release of my medical records to the program administrator or designee.

Date

Employee's Signature (or Designee, if necessary)

Human Resources Department Use Only:

Number of days approved as of _____
Date Days

Period Covered: _____
From To

Signature – Pool Administrator

Date

Signature – Designee

Date