EAST HOLMES LOCAL SCHOOLS
Sick Leave Assistance Program

Request to Donate Sick Days

Donating Employee's Name: _____

Donating Employee's SS#: _____

# of Days to be Donated: _____ (Limit of 2 whole days only)

I agree that the day(s) I donate will be matched by the District, and that I am responsible for repaying the District for the cost of the day(s) that I donate, at the receiving employee's rate of pay.

_____ Once determined by the Treasurer's office, I will pay by check

_____ Please deduct cost of my donation from my paycheck

_____ One Pay _____ Two Pays

Signature: _____ Date: _____

Employee to whom days are being donated: _____

For Treasurer's Office Use Only:

Receiving Employee's Daily Rate : _____

Benefits paid by Board:

Retirement	14%	_____
Medicare	1.45%	_____
Other	_____	_____
Total Board Benefits		

Total Cost of Receiving Employee's Daily Rate _____

Number of Days Being Donated (2 Maximum) _____

Total Cost to Donating Employee _____