

**CITY OF ELGIN
SICK LEAVE DONATION REQUEST FORM**

Employee Name: _____

Job Title: _____ **Dept:** _____

1. Are you unable to perform your regular work duties as documented by a medical doctor's certification?

_____ yes _____ no

2. Are you a full time employee: _____ yes _____ no

3. Do you have at least one year of service with the city? _____ yes _____ no

4. Have you provided all requested Family Medical Leave forms to Human Resources?

_____ yes _____ no

Signature

Date

PLEASE SUBMIT COMPLETED FORM TO HUMAN RESOURCES

Request for Sick Leave Donation: _____ **Approved**

_____ **Not Approved**

Human Resources