Shared Sick Leave Pool Request Form
RECIPIENT AFFIDAVIT

Request to Use Shared Sick Leave

I request participation in the Shared Sick Leave Program under the terms specified in the specific nature of my illness will be kept confidential.

Name of Recipient (Print)	Employee ID #	FTE (e.g., 1.0, .75, .50)
Department & P.O. Box	Email	Phone #

Date Medical Condition Began

Date Medical Condition Ended (or is expected to end)

I have not directly or indirectly solicited donations of sick leave time from other Valdosta State University employees independently. I have not interfered with any right which another employee may have with respect to contributing, receiving or using sick leave under this program. I am submitting herewith medical verification (Physicians Certification of Emergency) which confirms a life-threatening or emergency medical or mental health condition as described in the Valdosta State University Shared Leave Program policy. I certify that the above statements are true and complete to the best of my knowledge. If I am acting on behalf of the employee recipient, I am providing documentation as such with this form.

Signature of Recipient
or Authorized Recipient Representative

Date