## <u>SMYRNA SCHOOL DISTRICT</u> <u>RDD – REQUEST TO MAKE A DIRECT DONATION</u>

PART I - To be completed by donor employee .

| Donor's Name                                                                                                      | Social Security #                                                                                                                                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Building                                                                                                          | Phone #                                                                                                                                                                                                                                                                       |  |
| I hereby donate days of sich                                                                                      | k leave to:                                                                                                                                                                                                                                                                   |  |
| Recipient's Name                                                                                                  | Building                                                                                                                                                                                                                                                                      |  |
| understand that my annual sick leaved indicated above. I further certify the retirement date. If requested by the | leave that I must donate unused annual sick leave. I<br>we balance will be reduced by the number of days donated<br>hat this donation is not within 6 months of my planned<br>e recipient you may may not release my name and<br>nt. You may may not contact me if additional |  |
| Donors Signature                                                                                                  | Date                                                                                                                                                                                                                                                                          |  |
| UPON COMPLETION, PLEASE FORWARD TO THE PAYROLL OFFICE                                                             |                                                                                                                                                                                                                                                                               |  |
| PART II - To be completed by District                                                                             | Payroll Office                                                                                                                                                                                                                                                                |  |
| I certify the following:                                                                                          |                                                                                                                                                                                                                                                                               |  |
| Donors name                                                                                                       | Daily rate of pay (state share)                                                                                                                                                                                                                                               |  |
| The donor has sufficient annual sick lea                                                                          | ave to cover the donation indicated in Part I.                                                                                                                                                                                                                                |  |

Authorized Signature

Date

## PART III - To be completed by District Personnel/Payroll Office

Circle the action taken on the leave donation covered by this form and complete the information.

 I have attached a copy of a Donated Leave Calculation Worksheet for \_\_\_\_\_\_for the pay period ending \_\_\_\_\_\_ which has been approved by the District Finance Director.

The donor's sick leave account should be charged for the following:

| days | pay cycle |
|------|-----------|
| days | pay cycle |
| days | pay cycle |
| days | pay cycle |

2. The recipient has excess leave donation. The donor's leave donation is not needed at this time.

I certify the above information and further certify that the recipient has made application and been approved for receipt of donated leave.

Authorized Signature

Date

## PART IV - To be completed by District Payroll Office

I certify that the donor's sick leave balance has been reduced by \_\_\_\_\_ days.

Authorized Signature

Date