

LEAVE DONATION REQUEST DESIGNEE

City of Mandan
Form MMC 04-07-04(8) April 2014

Employee Name (Last, First, Middle Initial) Designee	
Department	Reference Personnel Policy: 04-07-04 (8) for policy details.
<p>I am applying (designee) for a leave donation. I understand that city employees may donate leave to me as follows:</p> <ol style="list-style-type: none"> 1. Annual leave if I, a relative, or household member is suffering from an extraordinary or severe illness, injury, impairment or physical or mental condition that has caused or is likely to cause me to take leave without pay or terminate employment. These terms do not include conditions associated with normal pregnancy. Also, leave donated to me may only be used by me for the purpose specified; is not payable in cash; and cannot exceed 4 months, including both annual and sick leave, in any 12-month period. (MPP 04-07-04 (8)) 2. Sick leave if I am suffering from an extraordinary or severe illness, injury, impairment, or physical or mental condition that has caused or is likely to cause me to take leave of absence without pay or terminate employment. These terms do not include conditions associated with normal pregnancy. Also, sick leave donated to me may only be used by me for the purpose specified; is not payable in cash; and cannot exceed 4 months, including both annual and sick leave, in any 12-month period. (MPP 04-07-04 (8)) <p>Leave donations I wish to receive: <input type="checkbox"/> Annual Leave Estimated Number of Hours _____</p> <p style="margin-left: 150px;"><input type="checkbox"/> Sick Leave Estimated Number of Hours _____</p>	
<input type="checkbox"/> I certify that all leave available to me including sick leave, annual leave, and compensatory time has been used or <input type="checkbox"/> I certify that all leave available to me has not been used but will be used by _____. <div style="text-align: right;">(Date)</div>	
<input type="checkbox"/> Attached is a medical certificate from a licensed physician or health care practitioner verifying the severe or extraordinary nature and expected duration of the condition.	
Employee Designee Signature	Date

City Administrator Review

<input type="checkbox"/> Request is approved. Administrator Signature _____ Date _____
<input type="checkbox"/> Request is denied for the following reason(s): Administrators Signature _____ Date _____