VALDOSTA STATE UNIVERSITY
Building for Our Next Century
1906-2006

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 University's Program description, and with the understanding that 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

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A Unit of the Division of Business & Finance
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