

APPLICATION FOR USE OF DAYS THROUGH LEAVE DONATION PROGRAM

As provided for in Fayette County Board of Education (FCBOE) Policy A-30a, I wish to request use of personal days through the Leave Donation Program. Attached to this application is all documentation regarding the catastrophic medical emergency of mine or my immediate family member.

By submitting this application, I am indicating that I have less than five accrued personal leave days remaining in my leave balance.

Please complete the following information, ensuring that you identify the number of days that you are requesting through the Leave Donation Program.

NAME: _____

MAILING ADDRESS: _____

EMPLOYEE IDENTIFICATION NUMBER: _____

PLACE OF EMPLOYMENT (SCHOOL): _____

NAME OF ATTENDING PHYSICIAN: _____

IDENTIFICATION OF CATASTROPHIC MEDICAL EMERGENCY: (Be certain to include all documentation regarding the catastrophic medical emergency):

(Physician's statement must be attached in order to process this application.)

NUMBER OF DAYS I REQUEST TO RECEIVE FROM THE LEAVE DONATION PROGRAM:

_____ Number of Days Requested from the Leave Donation Program

I affirm that the information provided above is accurate and complete.

Signature: _____

Date: _____

Witness (21 years or older): _____

Date: _____

Please submit this application to the following:

Superintendent of Schools
Fayette County Schools
Finance Department
111 Fayette Avenue
Fayetteville, WV 25840