Request to Use Donated Sick Leave Days (Caregiver)

Return Completed Form To:	Date Requested:
Return Completed Form To: Sick Leave Donation Plan Administrator Attn: Human Resources Director 145 S. Park Street DeFuniak Springs, FL 32435 **Or Fax To:** 850-892-1190	Date Requested:

Requester/Recipient's Name:	Employee ID #:
Cost Center:	
Date absence began or will begin:	Through (if known):

I certify I am a caregiver of _____________________________ who is my (please circle one) spouse, child, parent or sibling who has suffered a documented illness, accident or injury requiring treatment by a physician, which requires the need for a caregiver. I am in need of a minimum of five (5) days sick leave.

I authorize WCSD to use my name in my request for a need for care giving services.

Requester's Signature:____ Phone Number:________________________

Medical Certification of the Patient - CONFIDENTIAL

To Medical Practitioner: Based on my current need for a caregiver, since you examined me during my current illness, accident or injury, I am requesting you to complete the following information and answer any relevant questions asked by WCSD's Sick Leave Donation Plan Administrator.

Date Requested: ________________ Patient or Guardian's Signature: ____

****THE FOLLOWING IS CONFIDENTIAL MEDICAL INFORMATION****		PLEASE PRINT
Print Medical Practitioner's Name:		Business Telephone:
Mailing Address:		
License #:	State Issued:	Date of Issue:
Patient Name:		
Brief explanation of medical condition:		
Date patient was first examined for current condition:		
Estimated time that the patient needs a caregiver: Beginning____ Ending____		
Medical Practitioner's Signature:		Date: