

**APPLICATION  
For  
DONATED LEAVE**  
Complete all entries carefully and legibly  
(Please type or print)

For Office Use Only

|         |
|---------|
| Claim # |
|---------|

|  |                          |                       |                     |
|--|--------------------------|-----------------------|---------------------|
| Last Name  | First Name               | Middle Initial        | Social Security No. |
| Street Address   | City                     | Zip Code              | Home Telephone No.  |
| Department   | County Date of Hire      | Classification        |                     |
| Describe Nature of Disability and Cause  |                          |                       |                     |
| Were you hospitalized<br>$\pi$ Yes $\pi$ No  | Dates hospitalized       | Hospital              | Address      Phone  |
| Attending Physician  | Address                  | Phone                 |                     |
| List Other Sources of Income Related to This Disability, if any:   | Social Security Benefits |                       |                     |
| <u>Source</u>  | <u>Per Week</u>          | \$                    | Per Week            |
|  | \$                       | Worker's Compensation |                     |
|  | \$                       | \$                    | Per Week            |
| I hereby certify that for the period covered by this claim I am totally disabled and not working (unemployed) and that the above statements to the best of my knowledge are correct, complete and true. Furthermore, I certify that I am not receiving other income for this disability except as stated above and I will promptly notify the Polk County Department of Human Resources if I receive any new benefits or subsequent increases on current benefits. |                          |                       |                     |

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

**FOR DEPARTMENTAL USE ONLY**

|                                       |  |                   |
|---------------------------------------|--|-------------------|
| <b>Accumulated Benefits This Date</b> |  |                   |
| Sick Leave                            | Vacation   | Compensatory Time |
| Other Accumulated Leave               | Date Employee Will Have Exhausted All Accumulated Leave Benefits |                   |
| Signature of Department Head          | Date   |                   |