MUSKEGON COUNTY
MICHIGAN

Donated Leave
Employee Request Form

EMPLOYEE INFORMATION

Employee ID	Last Name	First Name	MI	E-mail Address
_____	_____	_____	__	_____

EMPLOYMENT INFORMATION

Position	Fund	Orgn	Department
_____	_____	_____	_____

Full/Part Time/Hourly:	Hourly
Vacation Balance:	_____
Sick Time Balance:	_____
FMLA Approved:	**Yes:** ☐ No: ☐
Reason for Requesting Donated Leave:	_____
Number of Hours of Donated Leave Requested:	_____
Name of Health Care Provider :	_____
Have You Received Prior Donated Leave ?	**Yes:** ☐ **No:** ☐
List Medical Condition for Which you Previously Received Donated Leave:	_____
Employee Signature:	_____ **Date:** (mm/dd/yyyy) _____

ADMINISTRATION USE ONLY

Donated Leave Request Granted:	☐ **Date:** (mm/dd/yyyy) _____
Donated Leave Request Denied:	☐ **Date:** (mm/dd/yyyy) _____
Reason for Denial:	_____
Authorized Signature:	_____ **Date:** (mm/dd/yyyy) _____