NRHEG Public School ISD #2168

Request to Receive Donated Sick Leave Form

Rev. 2-2-2024

I, _____, have read and understand my bargaining unit's Master Agreement Sick Leave Bank Policy. I have read the terms and conditions set forth therein and understand that this is a voluntary program resulting from the donations of my co-workers.

I certify that I am submitting this request due to a serious accident/illness of self, spouse, children, siblings, parents, or spouse's parents and that I will notify the District's Payroll Manager as soon as the medical emergency ends.

I further certify that I will not use any donated Sick Leave Days for any purpose other than the accident/illness described in the physician's verification of accident/illness documentation.

Please provide relevant information to this request. All information submitted is considered confidential and is only available to the Sick Leave Donation Committee for the purpose of approving or denying the request.

Total accrued Sick Leave Days (salaried employees)/Hours (hourly employees) available: _____

Estimated Sick Leave Days (salaried employees)/Hours (hourly employees) required: _____

Total Sick Leave Days (salaried employees)/Hours (hourly employees) requested to be donated: _____

I expressly waive and release any and all claims against the bargaining units, Independent School District No. 2168, its employees, officers, or agents arising out of its Sick Leave Sharing Bank Policy, how it is written, how it is administered, the documentation required, my application for leave under this policy, and any denial or cancellation of leave. This waiver and release specifically includes any claims under the Minnesota Human Rights Act and the Americans with Disabilities Act.

I understand that pursuant Minn. Stat. § 363A.31, I may rescind this release within fifteen (15) calendar days of its signing. In order for the rescission to be effective, it must be delivered to:
NRHEG Public School District No. 2168, Payroll Manager
306 Ash Avenue S.
New Richland, MN 56072

Employee's Name: _____ Date of request: _____
Employee's Signature: _____

Physician's verification of accident/illness included: Yes _____ No _____

Any verification not included with this form must be provided within ten (10) days of the date this application is submitted.