

**COUNTY OF MILWAUKEE
APPLICATION FOR ACCRUED TIME OFF DONOR PROGRAM
PHYSICIAN'S STATEMENT OF EMPLOYEE'S DISABILITY**

Date: _____

To: Director of Human Resources
Department of Human Resources
Room 210, Courthouse
901 N. 9th Street
Milwaukee WI 53233

Subject: **APPLICATION FOR ACCRUED TIME OFF DONOR PROGRAM - PHYSICIAN'S STATEMENT**

Chapter 17.186 of the General Ordinances of Milwaukee County, Accrued Time Off Donor Program for Employees who Have Exhausted All of Their Accrued Sick Leave, provides that an employee who has utilized all of his/her available accrued off time, including sick leave because he/she is suffering from a potentially terminal illness, is allowed to receive donations of accrued time-off from other employees who have elected to donate accrued time off to that employee in need of such time. Only employees who are not represented by a collective bargaining unit and those employees who are members of a collective bargaining unit which has elected to recognize the Accrued Time Off Donor Program in its memorandum of agreement, or by a collateral agreement with Milwaukee County, shall be eligible to donate time to an individual eligible for receipt of such time.

Instructions to employee: If you are applying for donated time, have your attending physician provide the requested information on this form.

Instructions to physician: Please complete this form and return to the Director of Human Resources.

This is to certify that (employee)_____ has been under my professional care since_____. It is my medical opinion that the employee has a potentially terminal illness due to (state diagnosis and prognosis): _____

Signature of Physician

Date

Physician's name, address, and phone number (Please print):

