

**COUNTY OF MILWAUKEE
APPLICATION FOR ACCRUED TIME OFF DONOR PROGRAM
RECEIVE ACCRUED DONATED TIME**

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 DONOR PROGRAM - TO RECEIVE DONATED TIME**

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.

STATEMENT OF INTENT

I, _____, hereby request authorization to participate in the Time Off Donor Program as outlined in Chapter 17.186 of the General Ordinances of Milwaukee County, due to a potentially terminal illness as substantiated by the attached physician statement.

RELEASE OF INFORMATION

I authorize _____ to release to the Milwaukee County Department of Human Resources, or their duly authorized representative, any requested information related to my medical condition, my ability to perform my related duties, or my ability to eventually return to work. The authorized release of this information is intended for the sole purpose of determining my eligibility for Milwaukee County's Accrued Time Off Donor Program, as defined by Chapter 17.186 of the General Ordinances of Milwaukee County. I understand Milwaukee County Human Resources, at its discretion may seek additional medical opinions as to verify the nature of my health condition.

Employee Signature Date

PRINT THE FOLLOWING INFORMATION:

EMPLOYEE NAME: _____

EMPLOYEE CLOCK NO.: _____

DEPARTMENT NAME: _____

PAYROLL UNIT NUMBER: _____