TULARE COUNTY
VACATION DONATION PROGRAM:

REQUEST TO PARTICIPATE FORM

I, _____, _____, _____
(Name) (Classification) (Emp Id #)
am requesting to participate in Tulare County's Vacation Donation program in accordance with Personnel Rule 6.8.8.

_____ _____ _____
Department Work Location Work Phone #

Please Check One:
[ ] I have recently experienced a catastrophic injury or illness. (Please explain.)
_____
_____
_____

[ ] A member of my immediate family, as defined in Personnel Rule 6.7.4 c), has recently experienced a catastrophic injury or illness. (Please explain and indicate relationship.)
_____
_____
_____

Required: Please attach your (or your immediate family member's) Physician's Certification for review.

I have exhausted or will soon exhaust my sick leave, vacation and CTO balances. My current balances as of _____ are:
(date)

Sick Leave Balance: _____
CTO Leave Balance: _____
Vacation Leave Balance: _____
Personal Holiday Balance: _____
Mandatory Time Off Balance: _____

I certify that I will accept any donations and understand that they will be counted as compensable earnings subject to all applicable taxes. Additionally, I am not eligible for, nor will I apply for Workers Compensation or 4850 payments. I have read and understand the Vacation Donation program and agree to abide with the procedures. I understand that I can only be on the Vacation donation program and receive donations for a maximum of twelve months (26 pay periods) during my tenure with the County. Additionally, any donations will be processed and credited to the recipient in numerical order until there are enough donated hours to make up a full pay period of hours, i.e. 80 hours for a full-time employee or the number of assigned hours for a part-time employee. I understand that if I'm receiving State Disability Insurance payments that I must provide such information to my payroll department so that the necessary integration of donated hours can occur.

I certify that the information contained in this form is a full, true and accurate representation of the facts as stated. A Physician's Certification from my or family member's health-care provider is attached.

Employee's Signature _____ Date _____

HR&D Use only:
HUMAN RESOURCES & DEVELOPMENT DEPARTMENT
[ ] Approve [ ] Deny Signature _____ Date_____
Recipient Identification #_____

If approved, please send copies to: Employee; Employee's Payroll Dept; Auditor's Office Payroll; HR&D Benefits