Alachua County Public Schools

Division of Human Resources

Compassionate Leave Program Application Form

Employee Information

Employee Name:_____ Employee ID:_____

Work Location:_____ Position:_____

Pursuant to Section 1012.61 of Florida Statutes and the Collective Bargaining agreement, I would like to use compassionate leave. I understand that the leave must be used for a serious health condition or life-altering event of myself or a member of my immediate family or for someone residing in my household, for whom I am the primary caregiver. I further understand that I must have been an employee for at least one (1) full year prior to the current fiscal year and must have used all available sick leave and vacation leave prior to receiving any donated leave.

The Physician's Statement Form or other appropriate documentation must be submitted to Human Resources in order to establish your eligibility to receive donated leave. No donated leave will be transferred to you until this form has been received by the Human Resources Department.

Leave Information

Leave Absence Dates: From:_____ To:_____

Last Day of Available Paid Leave:_____ Hours Worked Per Day:_____

Explanation of Circumstances Regarding Leave Requests:

I understand that upon my return from leave, any unused donated leave will be returned to the donating employee(s).

Signature of Employee:_____ Date:_____

➔ Please return this form to: Personnel Services Department (ATTN: Compassionate Leave Program) ←
620 East University Avenue, Gainesville, FL 32601

Office Use Only

Application Approved ☐ Denied ☐ _____ _____

Authorized Personnel Signature *Date*

Application Approved ☐ Denied ☐ _____ _____

Human Resources Supervisor Signature *Date*