CONFIDENTIAL

CITY OF POMONA

HUMAN RESOURCES DEPARTMENT
EMPLOYEE REQUEST DONATION OF LEAVE FORM

PART I -- EMPLOYEE'S INFORMATION

EMPLOYEE NAME: _____ TITLE: _____

DEPARTMENT/DIVISION: _____

JUSTIFICATION:

_____

(Employee shall attach a report from the health care provider and include any other documentation to substantiate the request). Do not include diagnosis.

_____ _____
Employee's Signature Date

DEPARTMENT DIRECTOR: PLEASE FORWARD THIS FORM ALONG WITH PHYSICIAN CERTIFICATION TO THE HUMAN RESOURCES DEPARTMENT

_____ _____
Department Director's Signature Date

PART II -- HUMAN RESOURCES DEPARMENT

☐ Verification of eligibility by _____ _____ _____
(Print Name) (Initial) (Date)

☐ APPROVED ☐ DISAPPROVED

JUSTIFICATION FOR DISAPPROVAL:

_____

_____ _____
Human Resources/Risk Management Director's Signature Date