WHITE MOUNTAIN APACHE TRIBE

REQUEST FOR TRANSFER OF LEAVE FOR MEDICAL PURPOSE

(Pursuant to Resolutions No. 10-94-320 and No. 3-99-54

TO: Human Resource Director

DATE: ____________________

FROM: ____

Last Name, First Name M.I. SOCIAL SECURITY

I am presently employed by the Tribe with the ______________________(Dept/Enterprise) and have accured _______ of annual leave and __0__ of sick leave.

Because I have unused leave which I will not need. I agree to transfer my accrued hours of leave as follows. I understand that I will lose these hours permanently, and I also understand that transfer will be done following guidelines set forth in the resolutions noted above, and I understand that it must be for medical purposes only, not for obtaining 80 hours of payroll hours, or that I may be leaving employment with the Tribe, or for any other reason that is not consistent with the leave transfer policy. I further understand that the transfer of annual/sick leave will be paid at the lower rate of the employee (receiving or donating). I understand that final approval of this leave transfer request is subject to disapproval on the basis of my employment status.

____________________________ ____________________________

Full Name of Receiving Employee Receiving Employee's Department

___0___ Hours of Sick Leave to be transferred _______ Hours of Annual Leave to be transferred

Date: ____________________

____

Signature of Donating Employee

NOTE: Leave cannot be transferred to/from any FATCO or CASINO Employee, as they have their own stipulation for leave accruals and personnel policy regarding leave.

RECEIVER'S STATEMENT

I, ______________________ am hospitalized or suffering from a severe illness and have used, or am about to use, all of my accrued leave time. Because I am not able to work for an extended period of time, I hereby request that the leave time noted above be transferred, so that I may be paid for my FUTURE absence from work. I certify that I am not eligible to utilize short term disability insurance coverage or other insurance coverage which I may have, to assist me during my medical leave, and, as a last resort, make this request for transfer of leave strictly for medical purposes, and am not making any retroactive payment requests for prior unpaid leave.

____

Signature of Receiving Employee / Date

PHYSICIANS STATEMENT

I verify that ______________________ is hospitalized or suffering from a severe illness which requires his/her absence from work from __________________ to __________________.

Signature of Physician	Printed Name of Physician	Physician's Office Name and Phone #

SUPERVISOR'S SECTION

I, hereby certify that ______________________, an employee under my supervisory authority, has notified me of his/her intent to transfer leave hours to ____________________ for medical purposes only, and I hereby affirm that said employee is able to transfer _________ hours of leave and that the budget of the receiving department/office can adequately handle the expense which this transfer of leave hours will create.

Date: ____________ Signature of Supervisor of Donating Employee

Date: ____________ Signature of Supervisor of Receiving Employee

Date: ____________ Signature of Director of Human Resources