AFIN REQUEST FOR LEAVE

AFIN (A Friend in Need) is a program designed to help fellow employees in time of need. This program is completely voluntary. If you are in need of time off due to illness of self/ family member, but have no leave time available, you may request to have leave donated to you. Please read this form carefully and completely before signing.

ACKNOWLEDGEMENT

I, ______________________________________, do hereby acknowledge that I have read this form carefully and completely. Furthermore, I understand the guidelines and purpose of the AFIN program, and release from any and all liability and hold harmless the Unified Personnel System, Pinellas County Government, and all of its officers and employees. This includes, but is not limited to, Employee Benefits and Finance/Payroll. In completing and signing this form, I acknowledge the following:

- I have met program guidelines either for myself or family members and understand that I must provide documentation of a serious health condition.
- I am no longer eligible for or have exhausted wage replacement benefits under any other County, federal, state or local benefit plan.
- I have completed and signed this form of my own free will.
- I understand that it is my responsibility to inform the Personnel Program Administrator of my need for a donation prior to payroll deadline.
- I understand donations received shall be subject to withholding taxes.
- All leave donated in excess of the employee's needs shall be returned to the donor(s).

RECIPIENT OF LEAVE

Name: ____________________________________ Emp #:_________

Appointing Authority/Department: ______________________________________

Requested Hours: _______ 8 hour increments
Not to exceed 160 hours per fiscal year

Signature: _________________________________ Date: ___________

Forward this Request to Employee Benefits for Processing

Hours Approved: _____________

Personnel Program Administrator Approval: _________________________ Date: ___________