REQUEST FOR ORGAN DONATION LEAVE

Employee Name: ___________________________ Employee ID# ______

Department: ____________________________________________________

_________________________ ________________________________
Employee Signature Date

TO BE COMPLETED BY PHYSICIAN:

I, ______________________ certify that ______________________________
(Physician’s name) (Employee’s name)

is donating (select one): □ a portion of their liver, □ a kidney, □ bone
marrow or other organ ________________ (please specify) and will require
leave beginning on ____________________ and ending on_________________.

_________________________ ______________________________
Physician’s Signature Date

FOR DEPARTMENT USE ONLY:

_________________________ ______________________________
Supervisor Signature Date