SMYRNA SCHOOL DISTRICT
ASP – AUTHORIZATION TO RELEASE INFORMATION FOR SOLICITATION PURPOSES

To be completed by employee seeking leave donations from other employees.

Name (Last, First, M.I.):

_____

Building: –

Date of accident or beginning of illness.	Date became unable to work	Date plan return to work

Briefly describe the nature of the injury/illness.

_____

Date all sick leave will be exhausted	Date ½ annual leave will be exhausted (if applicable)	Date all annual leave will be exhausted (if applicable)

_____

Other sources of Income Continuation (complete if eligible; otherwise indicate "not applicable")

I understand that leave donations will be normally solicited in the following order:

1. The employees listed below with whom I have already spoken to about a donation.

Name	Building

2. All district employees.

I hereby authorize release of the information indicated above to solicit days on my behalf under the Smyrna School District Donated Leave Program. I understand that this information will be shared with employees requesting information in connection with my request for leave.

_____ _____

Employee Signature Date