

LEAVE DONATION PROGRAM – DONOR FORM

NAME (PRINT)	LAST	FIRST	MIDDLE INITIAL	DATE:
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EMPLOYING AGENCY: _____

LEAVE DONATION FOR PAY PERIOD ENDING _____, _____, 20__

NUMBER OF HOURS DONATED

TYPE(S) OF LEAVE DONATED

	Vacation
	Sick leave
	Personal leave
	Compensatory time
	Total hours donated (must equal 8 or more hours)

PERSON TO RECEIVE LEAVE

EMPLOYEE NAME (PRINT)	LAST	FIRST	MIDDLE INITIAL
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EMPLOYING AGENCY: _____

CERTIFICATION

I hereby certify that this request is made voluntarily. I was not coerced, intimidated or financially induced into donating leave. By signing I hereby relinquish all rights to the leave shown above and the benefits accruing to or attached to the same. I understand that the donation of leave is irrevocable and irreversible and that no leave will be refunded to me. I certify that I will have a remaining balance of 80 hours or more of sick leave after making this donation.

SIGNATURE OF DONATING EMPLOYEE

DATE