

Confidential Record

LEAVE DONATION FORM

INFORMATION ABOUT DONOR

NAME: _____ TITLE: _____

SALARY GRADE: _____ NEGOTIATING UNIT: _____

WORK PHONE NUMBER: _____ AGENCY: _____

WORK LOCATION: _____ ITEM NUMBER: _____

RELATIONSHIP TO RECIPIENT: _____

INFORMATION ABOUT RECIPIENT

NAME: _____ TITLE: _____

SALARY GRADE: _____ NEGOTIATING UNIT: _____

AGENCY: _____ WORK LOCATION _____

DONATION INFORMATION

NUMBER OF DAYS DONATED: _____

AUTHORIZATION:

I hereby authorize the personnel office to deduct from my vacation balance the number of days indicated above to be used as sick leave by the recipient named above. I certify that the days donated are not days I would otherwise forfeit and that this donation does not cause me to drop below a balance of ten days of vacations of the date this donation is submitted.

DATE: _____ SIGNATURE OF DONOR: _____

Certification by agency personnel/payroll office (when donations are made to eligible family members in other agencies)

I certify that the donor is eligible to donate and that the above number of vacation days donated has been subtracted from the donor's vacation balance.

NAME: _____ SIGNATURE: _____

DATE: _____ TITLE: _____ PHONE: _____

Mail or fax this form to personnel/payroll of recipient and retain a copy for donor's agency files.