Franklin County
Where Government Works

LEAVE DONATION PROGRAM – DONOR FORM

NAME (PRINT) LAST	FIRST	MIDDLE INITIAL	DATE:

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

_____

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**