

**LEAVE DONATION PROGRAM – DONOR FORM**

<b>NAME (PRINT)</b>	<b>LAST</b>	<b>FIRST</b>	<b>MIDDLE INITIAL</b>	<b>DATE:</b>
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**EMPLOYING AGENCY:**

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**LEAVE DONATION FOR PAY PERIOD ENDING** \_\_\_\_\_, \_\_\_\_\_, 20\_\_

**NUMBER OF HOURS DONATED**

**TYPE(S) OF LEAVE DONATED**

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

**PERSON TO RECEIVE LEAVE**

<b>EMPLOYEE NAME (PRINT)</b>	<b>LAST</b>	<b>FIRST</b>	<b>MIDDLE INITIAL</b>
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**EMPLOYING AGENCY:** \_\_\_\_\_

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**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**