



OFFICE OF HUMAN RESOURCES
DONATED LEAVE FORM

SECTION I: DONOR INFORMATION

Employee Name: _____

Department/Office: _____

Division: _____

Leave Donation for
Payroll Period Ending: _____

NUMBER OF HOURS TO DONATE	TYPE OF LEAVE TO DONATE
	Vacation
	Sick Leave
	Personal Leave
	Total Hours to Donate

SECTION II: RECIPIENT INFORMATION

Use of donated leave is limited to 56 hours per pay period while awaiting disability benefits. Donated leave may not be used to supplement state-paid benefit program(s) (e.g. disability leave, adoption/childbirth leave, or workers' compensation).

Employee Name: _____

Department/Office: _____

Division: _____

SECTION III: 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 combined leave (sick, vacation, personal, and compensatory) after making this donation.

Signature of Donating Employee

Date