

**LEAVE SHARING DONATION FORM**

NAME \_\_\_\_\_

DATE \_\_\_\_\_

DEPARTMENT \_\_\_\_\_

EMPLOYEE # \_\_\_\_\_

I, \_\_\_\_\_, request to donate a portion of my paid time off, as indicated below, to the following co-worker: \_\_\_\_\_

check

**type(s) # of hours**

*(1/2 or full day increments only)*

\_\_\_\_\_ Personal Hours

\_\_\_\_\_ Sick Hours\* *(your sick leave balance must be 24 days (12 for Fire) after donation to be eligible)*

\_\_\_\_\_ Vacation Hours *(your vacation balance must be 5 days (3 for Fire) after donation to be eligible)*

\_\_\_\_\_ Wellness Hours

\*I understand that donations of sick time will lower on my annual sick check distribution from 75% to 50% even if I do not personally utilize sick time during this fiscal year.

I understand the following:

- the donation I am making can not be rescinded once I submit this form
- I will not be reimbursed or otherwise compensated by the listed recipient for the donation

***I VOLUNTARILY AUTHORIZE THE ABOVE DEDUCTION(S) OF PAID TIME OFF FOR THE PURPOSES OF LEAVE DONATION.***

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

HUMAN RESOURCES SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Human Resources Use Only:

Date Form Received: \_\_\_\_\_

Time Form Received: \_\_\_\_\_