

LEAVE DONATION PROGRAM -- DONOR APPLICATION FORM

FOR PAYROLL PERIOD ENDING: _____

I. DONOR INFORMATION

Donating Employee:

(Last) _____ (First) _____ (Middle Initial) _____ (Social Security Number) _____

Department: _____

Division _____ Employing Unit: _____

Number of hours donated	Type of leave donated
_____	_____
_____	Vacation
_____	Sick leave
_____	Personal leave
_____	_____
_____	_____
_____	TOTAL HOURS DONATED (Total must equal a minimum of 8 hours)
_____	_____

II. PERSON TO RECEIVE LEAVE

1. Use of donated leave is limited to 53.6 hours per pay period while awaiting disability benefits.
2. Donated leave may not be used to supplement state-paid benefit program(s) (e.g. disability leave, adoption/childbirth leave or workers' compensation).

Person to Receive Leave:

(Last) _____ (First) _____ (Middle Initial) _____ (Social Security Number) _____

Department: _____

Division: _____ Employing Unit: _____

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.

Date: _____
DAS ADM #4256 06/11

Signature of Donating Employee