LEAVE DONATION PROGRAM -- DONOR APPLICATION FORM

FOR PAYROLL PERIOD ENDING : _____

I. DONOR INFORMATION

Donating Employee :

(Last) (First) (Middle Initial) **(State of Ohio User ID)**

_____ _____

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 /*Workers' compensation).

Person to Receive Leave:

(Last) (First) (Middle Initial) (State of Ohio User ID)

_____ _____

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: _____ **Signature:** _____