LEAVE DONATION PROGRAM REQUEST FORM

Name:	
Classification:	
Institution/Dept.:	

Leave donations I wish to be eligible to receive: **Annual** ☐ **Sick** ☐

I am applying to be eligible for the leave sharing program. I understand that a state employee(s) may donate leave to me as follows:

☐ **ANNUAL LEAVE:** If I, a relative, or household member is suffering from an extraordinary or severe illness, injury, impairment, or physical or mental condition that has caused or is likely to cause me to take a leave of absence without pay or terminate employment. That leave donated to me may only be used by me for the purpose specified and is not payable in cash.

☐ **SICK LEAVE:** If I am suffering from an extraordinary or severe illness, injury, impairment, physical or mental condition that has caused or is likely to cause me to take leave of absence without pay or terminate employment. That sick leave donated to me may be used by me for the purpose specified and is not payable in cash.

I certify that all my leave (sick leave, annual leave, and compensatory time) has been used or will be used.

Dated used by: _____ Yes _____ No _____

I understand any shared leave not used by me may be retained by me.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Attach a medical certificate from a licensed physician or health care practitioner verifying the severe or extraordinary nature and expected duration of the condition.

Return to the Office of Human Resources for processing.

TO BE COMPLETED BY EMPLOYER

Request is (circle one): **Approved** **Denied**

Reason for denial:

Signature: Date:

12/13/2013