

Part I – To be completed by employee.

NAME: _____ EMPLOYEE ID #: _____

Agency Name/Department Number : _____

Work Address: _____
City State Zip

Work Phone: _____

Donations must be made in full-hour increments. The vacation leave balance must be at least 80 hours and the sick leave balance must be at least 480 hours after the donation is made – **UNLESS the donating employee is separating from the state service.**

PLEASE INDICATE THE TYPE AND AMOUNT OF LEAVE TO BE DONATED:

Vacation Leave Hours: # hours donated _____

To: _____
Name Employee ID# Agency

Sick Leave Hours: # hours donated _____

To: _____
Name Employee ID# Agency

I understand that my donation is voluntary and confidential. I understand my leave balance will be decreased by the amount contributed and this donation may affect the payout of sick leave upon retirement and the payout of vacation upon termination or retirement.

Employee signature Date

PART II – To be completed by agency personnel office:

Will the above named employee’s vacation leave balance be below 80 hours after the donation? Yes ___ No ___
Will the above named employee’s sick leave balance be below 480 hours after the donation? Yes ___ No ___

If the employee donating is separating from state service, please disregard the above questions and indicate below if they are retiring or terminating.

Terminating: _____ Retiring: _____ Current salary of donating employee: _____

PART III – To be completed by agency personnel office:

I hereby approve ___ deny ___ donation of leave for the above named employee (# Hours _____)

Appointing Authority signature: _____ Date _____