Leave Donation

To Donate Accrued Leave

DONATING EMPLOYE INFORMATION	
Name:	**Employee Number:**
Department:	**Department Number:**

LEAVE TO BE TRANSFERED	
Annual Leave: hours	**Sick Leave:** hours

RECEIVING EMPLOYEE INFORMATION	
Name:	**Employee Number:**
Department:	**Department Number:**

In accordance with the provisions of Madison County Policy creating the "Sick Leave Bank", I hereby certify that I wish to donate the above number of leave hours to the beneficiary employee listed above. Madison County HR has my permission to transfer the indicated number of hours to the beneficiary due to a catastrophic illness/injury as defined in the policy. I understand that my leave balance(s) will be reduced by the specified number of hours as needed by the recipient and that the donated hours are not revocable. If a sufficient balance of unused leave remains after the recipient's emergency has terminated, a pro-rated share will be returned to me.

Donating Employee Signature: _____ Date: _____

Donating Employee's Department Head Signature: _____ Date: _____

Receiving Employee's Department Head Signature: _____ Date: _____

TO BE COMPLETED BY HR	
Date Received:	**Date Posted:**