



LEAVE DONATION PROGRAM

DONOR INFORMATION:	
Employee Name:	
University Identification Number (UID):	
Department:	
DONATION:	
Type of Leave: <input type="checkbox"/> Sick _____ hrs. <input type="checkbox"/> Annual _____ hrs. <input type="checkbox"/> Comp (SP only) _____ hrs.	Total Hours of Donation: _____ Hrs. <small>(This is the combined sick, annual, and comp. hours donated and MUST be an increment of 8)</small>
RECIPIENT INFORMATION:	
Name:	
Department:	

AUTHORIZATION:

- I hereby authorize Human Resources to deduct from my leave balance the above-indicated number of hours, to be used as sick leave by the recipient named above.
- I certify that this donation does not cause my personal leave to drop below a combined balance of 80 hours following this donation.
- I acknowledge that any unused portion of the donated leave:
 - will not be retained by the Recipient,
 - will not be returned to me, and
 - will be transferred to the FGCU Sick Leave Pool account.

Donor's Signature Date

SUBMIT COMPLETED FORM TO THE HUMAN RESOURCE DEPARTMENT
 (Retain a copy of this form for your personal record and verify the transfer of leave on Gulfline)

For HR use only:	Date Entered: _____	Initials: _____
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