CENTRAL STATE UNIVERSITY

LEAVE DONATION PROGRAM—DONOR APPLICATION FORM

FOR PAYROLL PERIOD ENDING ____________________________.

I. DONOR INFORMATION

(LAST) (FIRST) (M.I.) (SOCIAL SECURITY NUMBER)

DEPARTMENT: ______________________________________

JOB TITLE: _______________________________________

SUPERVISOR’S SIGNATURE ____________________________ DATE: _______________

TYPE OF LEAVE DONATED:

                                   ANNUAL LEAVE [ ]

# HOURS DONATED ______

Note: The minimal amount of leave donation allowable is – eight (8) hours; the maximum allowable leave
donation is – forty (40) hours. The employee donating the leave must have a balance of at least eighty (80) hours
remaining in his/her annual and/or sick leave banks, after the donation. Accrued and unused paid leave donated
by any one employee may not exceed 160 hours.

II. PERSON TO RECEIVE LEAVE

(LAST) (FIRST) (M.I.) (SOCIAL SECURITY NUMBER)

DEPARTMENT: ______________________________________

JOB TITLE: _______________________________________

SUPERVISOR’S SIGNATURE ____________________________ DATE: _______________

1. Use of donated leave is limited to the average number of hours in the employee’s weekly scheduled tour of
duty.

2. Donated leave may not be used to supplement state-paid benefit program(s) (i.e. Disability Leave, Adoption/
   Childbirth Leave and/or Worker’s Compensation.)

(over)
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 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. I also understand that my identity as a donor is to be kept confidential and I will also honor that confidentiality.

SIGNATURE: ___________________________________________ DATE: ___________________________
Donating Employee

CHECK ONE:

[ ] FACULTY [ ] MONTHLY/EXEMPT STAFF [ ] BI-WEEKLY/NON EXEMPT STAFF

[ ] Regular Full-Time [ ] Regular Full-Time
[ ] Regular Part-Time [ ] Regular Part-Time

IV. VALIDATION – TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT

Annual Leave Balance Before Donation _______ Hrs. Number of Hours Donated _______ Hrs. New Annual Leave Balance _______ Hrs.

HUMAN RESOURCES COORD/REVIEW: __________________________________________________________
SIGNATURE ___________________________ DATE ___________________________

EXECUTIVE VP & CFO: __________________________________________________________
SIGNATURE ___________________________ DATE ___________________________

APPROVED: Yes [ ] No [ ]