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| **Donor Name** |  | **Site** |  |
| **Recipient Name** |  | **Site** |  |

|  |  |
| --- | --- |
| **Sick Leave Days Being Donated** |  |
| *Your remaining balance can’t be less than ½ of accumulated leave.* | |
| **Personal Leave Days Being Donated** |  |
| *Your remaining balance can’t be less than seven (7) days.* | |

**By signing this form, I understand that:**

* This is a voluntary donation
* Once made, the donation is irrevocable
* Donations must comply with **all** GPSD policies
* Donations will be pulled from my sick or personal leave time.

|  |  |  |  |
| --- | --- | --- | --- |
| **Donor Name** |  | **Date** |  |
|  | | | |

**To be completed by the Business/Payroll Office**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Recipient** | | | | | |
| FMLA Eligible |  |  | Yes |  | No |
| **Donor** |  |  | |  | |
| Donor’s Leave Balance meets or exceeds 7 days | |  | Yes |  | No |