SOUTHERN WEST VIRGINIA COMMUNITY AND TECHNICAL COLLEGE
BOARD OF GOVERNORS
SCP-2005.B

CATASTROPHIC LEAVE DONATION FORM

I. DONOR INFORMATION

Name: _____

SSN: _____

Job Title: _____

Department, Division, Branch/Office _____

(if employed with another agency within WVHE)

I wish to donate_____SICK LEAVE DAY(s)
I wish to donate_____ANNUAL LEAVE DAY(s)

II. RECIPIENT INFORMATION **(need only recipient Name unless donation is between agencies).**

Name: _____

SSN: _____

Job Title: _____

Department, Division, Branch/Office _____

(if employed with another agency within WVHE)

I certify that this is a voluntary donation of my accrued and unused sick and/or annual leave. Also, I understand that this donation will cause the reduction of my leave balance(s) as designated above.

Donor Signature Date

THIS BOX RESERVED FOR HUMAN RESOURCES FILE MAINTENANCE

TOTAL DAYS DONATED THIS FORM _____

C H A R G E D T O D O N O R

MTH	YR	TYPE	AMOUNT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FORM DISTRIBUTION:

❑ Recipient File - original

❑ Send to Donor - copy