



CATASTROPHIC LEAVE EMPLOYEE DONATION FORM

I. DONOR INFORMATION

Name: _____

Soc Sec Num: _____

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: _____

Soc Sec Num: _____

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 _____

CHARGED TO DONOR

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

FORM DISTRIBUTION:

Recipient File - original

Send to Donor - copy

cldonate.wpd June 15, 2001

DAYS REMAINING THIS FORM _____