

**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