CATASTROPHIC LEAVE DONATION FORM

I. DONOR INFORMATION

Name: _____

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: _____

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

Revised 3/2/2021