



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 HOURS*

I wish to donate _____ ANNUAL LEAVE HOURS*

*(37.5 hours = 4 days)

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 HOURS 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 02/06/2026