

**STATE SYSTEM OF HIGHER EDUCATION
REQUEST TO RECEIVE LEAVE DONATIONS**

RECIPIENT

Name of Recipient

Personnel Number

University

Department

I have used paid/unpaid leave for the following listed absences due to my, or my family member's, catastrophic illness/injury:

I am requesting donations of _____ days to cover future absence(s) that will exceed the 20 workdays of absence used for this reason.

This leave will cover the period from _____ to _____.

A Serious Health Condition Certification is attached to this request.

If leave donation is approved, the Human Resources Office will inform university/Office of the Chancellor employees that you or your family member have a catastrophic illness/injury and donations may be accepted. The nature of the illness will not be divulged.

Check here to authorize the Human Resource Office to announce that you are approved for leave donations. The nature of the illness will not be divulged.

Recipient Signature

Date

HUMAN RESOURCE OFFICE

Check all that apply:

Recipient is a permanent employee.

In the past six month period, the recipient has not:

--been placed on a written leave restriction

--received a written reprimand related to attendance

--received a suspension related to attendance

The absences listed above were for the recipient or family member's catastrophic illness/injury.

The absences were not due to a work-related illness/injury.

Recipient's years of service

Date when all accrued annual, sick, personal, holiday, and compensatory leave and all anticipated annual and sick leave was exhausted (as appropriate for an employee or family member).

approved

disapproved

Up to _____ hours of annual and personal leave may be donated.

HR Director Signature

Date