



HUMAN RESOURCES DONATED LEAVE REQUEST FORM

Employee Name _____ EE ID#: _____

Division/Section Name and Number _____

Leave Request

I am requesting leave for

Medical Reason

Non-Medical Reason

Beginning Date of Leave _____ to Approximate Ending Date of Leave _____

Your request can be for up to one year. You may re-apply after it expires.

On a Continuous Basis or Intermittent

I, the undersigned, have read and understand the donated leave policy. I attest that I am benefit eligible, have been employed for at least six (6) months and have exhausted all appropriate leaves. **I understand that I may not use donated leave until all other accrued leaves are exhausted.**

Donated leave shall be ended upon the employee's full release to work for medical reasons. Those using Donated Leave for non-medical reasons may use Donated Leave through their return date.

I agree to notify the Human Resources Division of any changes to the leave as requested above.

Employee Signature _____ Date: _____

Approval Signatures

Supervisor _____ Approved Denied – Reason: _____

Section Head _____ Approved Denied – Reason: _____

Division Director _____ Approved Denied – Reason: _____

Human Resources _____ Approved Denied – Reason: _____

Human Resources Use Only

Added to Human Resources webpage Date _____

Sent out email notification Date _____

Sent email to Payroll Date _____