BOARD OF REGENTS OF
THE UNIVERSITY SYSTEM OF GEORGIA

GEORGIA STATE UNIVERSITY

SHARED SICK LEAVE PROGRAM – MEMBER DONATION FORM

Employee Name: _____ Department: _____

Employee ID: _____ Hire Date: _____

Phone#: _____ Email: _____

I wish to donate _____ hours of sick leave (8 hour minimum and 80 hour maximum) (pro-rated for part- time employees) to be used as part of the Shared Sick Leave Program. The leave will be transferred to the sick leave pool effective January 1st, unless otherwise notified.

I hereby acknowledge the following:

- I have successfully completed my provisional period.
- I agree that my donation is strictly voluntary.
- I understand that I must donate a minimum of eight (8) hours and retain at least 40 hours of sick leave in my own account when donating sick leave. Hours are pro-rated for part-time employees.
- I agree that the hours that I am donating have already been accrued.
- I understand that after my leave donation has been charged against my leave balance, it is irrevocable and cannot be withdrawn.
- I understand that if the leave pool is depleted, I will be notified and automatically charged eight (8) hours, unless I wish to withdraw at that time.

I have read and understand the policies related to the **Shared Sick Leave Program** and agree to participate by signing my name and dating below.

Employee Signature: _____ Donation Date: _____

PLEASE COMPLETE AND RETURN THIS FORM TO:
Georgia State University Benefits Office, 1 Park Place, Suite 330, Atlanta, GA 30303-3928 or by fax to (404)413-3324

FOR USE BY THE OFFICE OF HUMAN RESOURCES

☐ Leave Donation Approved ☐ Leave Donation Denied

Denial reason and/or comments:

_____

_____

_____

Signature of Program Administrator: _____ Date: _____