(8/01)

KANSAS STATE UNIVERSITY
SHARED LEAVE PROGRAM
Shared Leave Donation Form

PART I - To be completed by employee.

Name ____________________ Employee ID # ____________________

Department ____________________

Work Address ____________________

____
(City) (State) (Zip)

Work Phone ____________________

Donations must be made in full-hour increments. Classified employees donating vacation leave must have at least 80 hours of accrued vacation leave after the donation is made. Classified and unclassified employees donating sick leave must have at least 480 hours of accrued sick leave after the donation is made, unless donating at the time of separation from state service.

Please indicate the type and amount of leave to be donated:

Vacation Leave Hours: # hours donated __________ to:

____
(Name) (Agency or Department)

Sick Leave Hours: # hours donated __________ to:

____
(Name) (Agency or Department)

I understand that my donation is voluntary and confidential. I understand that my leave balance will be decreased by the amount contributed. I understand this donation may affect the payout of sick leave upon retirement or the payout of vacation leave upon any termination.

____
Employee Signature Date

PART II - To be completed by the Division of Human Resources.

Will the above-named employee's vacation leave balance be below 80 hours if the above-mentioned number of vacation leave hours are donated? Yes __________ No __________

Will the above-named employee's sick leave balance be below 480 hours if the above-mentioned number of sick leave hours are donated? Yes __________ No __________

The donating employee's current salary is: __________

Is the donating employee terminating? Yes ______ No ______ If so, retiring or resigning? __________

____
Appointing Authority or Designee Signature Date

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PART III - To be completed by the appointing authority.

I hereby approve _______________ deny _________________ donation of leave for the above-named employee.

Appointing Authority or Designee Signature   Date

PART IV - To be completed by the Division of Human Resources.

The above-named employee's vacation leave balance has been reduced by ____________________ hours.

The above-named employee's sick leave balance has been reduced by ________________ hours.

Appointing Authority or Designee Signature   Date

PART V - To be completed by the Division of Human Resources.

(Receiving employee)   Department Name   Employee ID #

has been credited with _________________________ hours of shared leave.

Appointing Authority or Designee Signature   Date