SHARED SICK LEAVE PROGRAM ENROLLMENT FORM

Employee Name: ______________________________ Department: ________________________________

Employee ID: ______________________________ Email: art of the Shared Sick Leave Program. The leave will be transfe

leave pool effective January 1,

Phone #:______________________________________

less otherwise notified.

I hereby acknowledge the following:

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I understand that after my leave donation has been charged against my leave balance, it is irrevocable and cannot be withdrawn.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 policy related to the Shared Sick Leave Program and agree to participate by signing my name and dating below.

Employee Signature Leave Donation Approved Leave Donation Denied

Denial reason and/or comments:

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Signature of Program Administrator: ______________________________________ Date: ____________