Indiana State University
VOLUNTARY SICK LEAVE DONATION AGREEMENT

Donor's Name:_____________________________ Donor's ID#____________________________

Employee to Receive Hours _______________________________ Dept___________________

Number of hours being donated: _____________

I understand the following:

- I may transfer up to two (2) weeks per fiscal year.
- I must have a remaining balance of at least two (2) weeks of accrued sick leave after the transfer.
- I may not ask or expect the recipient to transfer time should I need additional sick leave in the future
- This transfer is irrevocable.
- This transfer may reduce my retirement sick leave payment benefit in the future (for support staff only)
- The recipient of my sick hours must have current FMLA paperwork on file or if not eligible for FMLA, must have a verified Medical Leave form
- The recipient must have used all balances of sick leave, vacation and convenience day (if applicable).

I am donating this leave of my own free will and have not been unduly influenced in any manner to make this contribution.

____ _________________

Donor's Signature Date

____ _________________

HR-Benefits Representative Date

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FOR HUMAN RESOURCES/PAYROLL USE ONLY (Record all data in hours)

Is recipient benefits eligible employee? Yes______ No_______
Dates of the recipient’s current FMLA or Medical condition on file. ____________________
Payroll transfer Date: _______________________________
Donor's balance at time of transfer: ____________________
Prior number of hours donated current fiscal year:_____________________

Approved HR:________________________________ Date: __________________

Processed/Payroll:______________________________ Date:___________________

Distribution: copy Recipient’s file copy Donor’s File