



# Shared Sick Leave Pool Enrollment Form

Employee Name: \_\_\_\_\_ Department: \_\_\_\_\_ Emp ID \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Hire Date: \_\_\_\_\_ Supervisor: \_\_\_\_\_

I have successfully completed my provisional period: Yes No

I wish to donate hours as specified below 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 1<sup>st</sup>, unless otherwise notified.

Number of Sick Leave Hours Voluntarily Donated

Check one:

8 16 24 32 40 48 56 64 72 80

Enrollment Date: \_\_\_\_\_

I hereby acknowledge the following:

- I agree that my donation is strictly voluntary and may withdraw from the pool at any time by completing the Shared Sick Leave Enrollment Termination form.
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I understand that after my leave donation has been charged against my leave balance, it is irrevocable and cannot be withdrawn.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: \_\_\_\_\_ Date: \_\_\_\_\_

FOR USE BY THE OFFICE OF HUMAN RESOURCES

Leave Donation Approved Leave Donation Denied Effective Date of Leave Transfer \_\_\_\_\_

Denial reason and/or comments:

Four horizontal lines for providing denial reasons and comments.

Signature of Program Administrator: \_\_\_\_\_ Date: \_\_\_\_\_