SAVANNAH STATE UNIVERSITY

Shared Sick Leave Program – Membership Termination Form

INSTRUCTIONS: If you wish to terminate your membership in the Shared Sick Leave Program, please complete this form and submit it to the Office of Human Resources

I request to terminate my membership in the University System's Shared Sick Leave Program.

Employee Name: _____ Employee ID: _____

Phone # : _____ Email: _____

Department: _____ Effective Date of Termination: _____

I acknowledge that I have read and understand the program provisions as set forth in the Shared Sick Leave Program policies. I understand that any sick leave that I have donated before the membership is terminated will be forfeited.

_____ _____

Employee Signature Date

FOR USE BY THE OFFICE OF HUMAN RESOURCES

Your termination of benefits has been received and processed. Thank you for your support of the Shared Sick Leave Program.

_____ _____

Program Administrator Signature Date