

WINTHROP UNIVERSITY LEAVE TRANSFER PROGRAM LEAVE DONATION REQUEST FORM

Name	Winthrop ID
College / Division	Department

I request that the amount of hours for the type(s) of leave listed below be transferred from my account to the University's leave transfer pool. I understand that once my leave credits have been transferred to the pool account, such credits will not be restored or returned to my account.

_____ Hours of Annual Leave

and/or

_____ Hours of Sick Leave

I understand that I may donate no more than one-half (1/2) of the sick or annual leave earned within a calendar year to the appropriate pool leave account for that calendar year, and that I must retain a minimum of 15 days of sick leave. I also understand that I may not specify to whom my donated leave may be awarded.

Employee Signature	Date
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Request Form must be received in Human Resources prior to December 15.

FOR HR USE ONLY
Class Code: _____
State Title: _____
Hourly Rate: _____
Leave Balance:
Annual: _____
Sick: _____
Adjusted Balance:
Annual: _____
Sick: _____
Credit Pool: _____

ACKNOWLEDGEMENTS	
_____ Supervisor	_____ Date
_____ Human Resources Representative	_____ Date