

LEAVE DONATION FORM

Print this form, fill out, sign and submit to your Personnel Department

DONOR INFORMATION

Name:	Title:	Salary Grade:
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Negotiating Unit:	Payroll Item Number:	Social Security Number:	Work Phone Number:
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Work Unit/Location:

RECIPIENT INFORMATION

Name: Wayne Marote	Work Unit/Location: State University College At Brockport 350 New Campus Dr Allen Admin 4th Floor Brockport, NY 14420-2997
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NUMBER OF VACATION DAYS DONATED

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AUTHORIZATION: I hereby authorize the Personnel/Payroll Office to deduct from my vacation balance the number of days indicated above to be used as sick leave by the recipient named above. I certify that the days donated are not days I would otherwise forfeit and that this donation does not cause me to drop below a balance of ten days of vacation as of the date this donation is submitted.

Date:	Signature of Donor:
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