LEAVE DONATION FORM

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

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DONOR INFORMATION

Name:	**Title:**	**Salary Grade:**

Negotiating Unit:	**Payroll Item Number:**	**Social Security Number:**	**Work Phone Number:**

Work Unit/Location:

RECIPIENT INFORMATION

Name:	**Work Unit/Location:**
Mainriks Doka	South Beach Psychiatric Center 777 Seaview Avenue Staten Island NY 10305

NUMBER OF VACATION DAYS DONATED

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:**
