

LEAVE DONATION FORM

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

DONOR INFORMATION

Name:	Title:	Salary Grade:
--------------	---------------	----------------------

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

Work Unit/Location:

RECIPIENT INFORMATION

Name: Melinda Keohan	Work Unit/Location: Shawangunk Correction Facility PO Box 750 Wallkill, NY 12589-0750
---	---

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:
--------------	----------------------------
