

Augusta University

Shared Sick Leave Program – Membership Termination Form

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

_____ Employee Name (Print)	_____ Empl ID #	_____ Department
_____ Email	_____ Phone #	_____ 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
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INSTRUCTIONS: Please complete and return this Termination of Membership form to the Benefits Analyst in Benefits & Data Management located in HS 1126 in the Annex I building.

FOR USE BY THE BENEFITS & DATA MANAGEMENT OFFICE

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

_____ Program Administrator Signature	_____ Date
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