

# AUGUSTA UNIVERSITY

## SHARED SICK LEAVE PROGRAM – ENROLLMENT/DONATION FORM

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Employee Name: \_\_\_\_\_ Department: \_\_\_\_\_  
Employee ID: \_\_\_\_\_ email: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Donation Date: \_\_\_\_\_

I wish to donate \_\_\_\_\_ hours of sick leave (8 hour minimum and 80 hour maximum) (pro-rated for part-time employees) to be used as part of the Shared Sick Leave Program. The leave will be transferred to the sick leave pool effective January 1<sup>st</sup>, unless otherwise notified.

I hereby acknowledge the following:

- I agree that my donation is strictly voluntary.
- I understand that I must donate a minimum of eight (8) hours and retain at least 40 hours of sick leave in my own account when donating sick leave. Hours are pro-rated for part-time employees.
- I agree that the hours that I am donating have already been accrued.
- I understand that after my leave donation has been charged against my leave balance, it is irrevocable and cannot be withdrawn.
- I understand that if the leave pool is depleted, I will be notified and automatically charged eight (8) hours, unless I wish to withdraw at that time.

I have read and understand the policies related to the [Shared Sick Leave Program](#) and agree to participate by signing my name and dating below.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NOTE: ALL FORMS MUST BE SUBMITTED TO HR BENEFITS & Data Management BY 5:00 PM ON  
November 8, 2019.

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### FOR USE BY THE OFFICE OF HUMAN RESOURCES

Leave Donation Approved       Leave Donation Denied

Denial reason and/or comments:

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Signature of Program Administrator: \_\_\_\_\_ Date: \_\_\_\_\_