



CATASTROPHIC LEAVE PROGRAM

DONATION OF ACCRUED SICK LEAVE FORM

Name (please print)

School/Department

Please select which category of sick leave you are using for donation.

- ☐ Newly hired full-time faculty
- ☐ Full-time faculty with accrued days of full-time sick leave
- ☐ Full-time faculty with accrued hours of overload sick leave
- ☐ Part-time faculty with accrued hours of sick leave

- I understand that I may voluntarily donate a maximum of two (2) days per year from my accumulated accrued leave, provided I have ten (10) days of accrued leave remaining at the time of the donation.
- I understand this donation is voluntary and irrevocable and I agree to indemnify and hold harmless the District from any loss or damages resulting from this program.
- I understand that my accrued leave will be used by an employee who has suffered a catastrophic illness/injury and has exhausted all paid leaves.
- I understand that confidentiality in the participation of this program will be maintained.

Number of sick leave **days** to be donated: ☐ One ☐ Two

Number of sick leave **hours** to be donated:

Minimum contribution:

Full-time: One day or 7 hours

Part-time and Overload: 4 hours

Employee Signature

Date

From the Payroll Department:

As identified above, _____ days _____ hours (check one) have been deducted from your accrued sick leave which leaves your balance at _____ days and _____ hours.