Middle Georgia State University
OFFICE OF HUMAN RESOURCES

## SHARED SICK LEAVE PROGRAM - ENROLLMENT FORM

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 benefits eligible 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, 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- I understand that after my leave donation has been charged against my leave balance, it is irrevocable and cannot be withdrawn.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 policy related to the **Shared Sick Leave Program** and agree to participate by signing my name and dating below.

Employee Signature: _____ Date: _____

**FOR USE BY THE OFFICE OF HUMAN RESOURCES**

☐ Leave Donation Approved ☐ Leave Donation Denied

Denial reason and/or comments:

_____

_____

_____

Signature of Program Administrator: _____ Date: _____