

STATE EMPLOYEES' LEAVE BANK DONATION FORM

Please complete this form if you wish to donate leave to **JOIN** or **RENEW** your membership in the State Employees' Leave Bank.

If you are joining the Leave Bank for the **FIRST TIME**, you must be a member for at least 90 days before you are eligible to receive leave.

EMPLOYEE TO COMPLETE

NAME: _____

*SOCIAL SECURITY #: _____

** Providing your full Social Security Number will help us to verify your identity. Failure to provide it may result in rejection of your membership. Your number will be kept confidential in accordance with Federal and State laws and regulations.*

AGENCY: _____

APPLICATION STATUS:

INITIAL

RENEWAL

REHIRE

I hereby certify that I am donating the following leave to establish membership in the State Employees' Leave Bank:

TYPE OF LEAVE	DONATED HOURS
Annual	
Personal	
Sick	

SIGNATURE OF EMPLOYEE

DATE

APPOINTING AUTHORITY TO COMPLETE

ANNUAL/PERSONAL LEAVE CERTIFICATION: I have reviewed this employee's leave balances and affirm that s/he has sufficient annual/personal leave to make this donation.

SICK LEAVE CERTIFICATION: I have reviewed this employee's sick leave balance. I affirm that s/he will have a sick leave balance of at least 240 hours after this donation is subtracted.

SIGNATURE OF APPOINTING AUTHORITY

DATE