

STATE EMPLOYEE LEAVE DONATION FORM

DONOR INFORMATION

Information About Donor

Name	Employee ID #
Title	Work Phone #
Department and Agency	
Address and Telephone #	

RECIPIENT INFORMATION

Information About Person to Receive Donation

Name	Department
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DONATION INFORMATION

Number of Vacation Days Donated:

(Please donate in whole days, i.e. 1 day, 2 days, 3 days, etc.)

AUTHORIZATION

I hereby authorize Payroll Services to deduct from my vacation balance the number of days indicated above to be used as sick leave by the recipient named above. I certify that the days donated are not days I would otherwise forfeit and that this donation does not cause me to drop below a balance of 10 (ten) days as of the date this donation is submitted.

Date	Signature of Donor
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Please return signed copy to the Human Resources Benefits Office, Room 204 Jacobsen Hall or fax to (315) 464-4390. For additional information please contact the Benefits Office at (315) 464-4943.

Please Mail to: Human Resources,
Attn of: Linda Mazzone,
SUNY Upstate Medical University,
750 E Adams St
Syracuse, NY, 13210

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