

**LCCAA Sick Leave Donation Form**

Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Department: \_\_\_\_\_

I wish to donate \_\_\_\_\_ hours to the sick leave bank. This donation is effective \_\_\_\_\_

I understand that I am limited to a donation of 16 hours in any fiscal year, and that I must have the hours available for donation.

I understand that once I donate these hours, the hours may not be refunded to me.

I agree that I am making a voluntary donation. I understand that this donation will be kept confidential at my request.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I want my donation to be kept confidential. YES \_\_\_\_\_ NO \_\_\_\_\_