LCC / AFT 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 24 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_______