ESP 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___________

This section is to be completed by the LCC Human Resources office and returned to the chair of the ESP Sick Leave Bank Committee.

____ ___________________________________

Signature Date