



LOWER COLUMBIA COLLEGE SHARED LEAVE DONATION FORM

Use this form only. No need to submit a leave request.

Name (please print)	SID#	Type of Leave Donating:
_____	_____	Vacation
Name of Person Leave is to be Donated	Hours/Days to be Donated	Sick Leave
_____	_____	Personal Holiday

I understand that:

1. This request is subject to approval;
2. This will not cause my annual leave balance to fall below eighty hours (10) days for Administrators, Exempt and Classified employees and/or faculty, my sick leave balance to fall below 176 hours (22) days; and
3. I have not been intimidated, threatened, or coerced donating leave for purposes of this program.
4. After the employee returns to work full-time, remaining leave may not be returned to donors until the condition is resolved OR until the employee has been working full-time for at least six months.

Signature of Leave Donor

Date of Request

HUMAN RESOURCES USE ONLY

Approved

Disapproved

Kendra Sprague, VP of Foundation, Human Resources & Legal Affairs

Date

PAYROLL USE

Date Entered into PPMS _____

Date Returned (If Any) _____

Amount Returned (If Any) _____

SUBMIT COMPLETED FORM TO HUMAN RESOURCES