KENT STATE UNIVERSITY

Leave Donation Program
DONEE Leave Request Form

Employee Name_____
(Last Name) (First Name) (Middle Initial)

Employee Banner ID #: _____ Job Title: _____

Department: _____ Work Phone #: _____

Home Phone #: _____ Last Day Worked: _____

Supervisor's Name: _____Supervisor's Work Phone #:_____

REQUEST

According to the provisions of the Leave Donation Policy, I, _____,
indicate my willingness to accept donated vacation and/or sick leave. My signature below certifies that:

1. I have a documented medical condition that warrants absence from work for an extended period of two weeks or more, as provided for under administrative policy 3342-6-26. *A copy of my Request for Leave of Absence form and medical documentation is attached.*
2. I realize that I cannot utilize donated leave time until all of my own accumulated vacation and sick leave accruals have been exhausted.
3. I understand that my name will appear on the University's list of employees in need of donated leave.
4. I am not receiving nor have I applied for lost wage benefits under Worker's Compensation, Long-Term/Short-Term disability or State Retirement.
5. I understand that I will not accrue vacation and sick leave while utilizing donated leave.

Submit original signed and completed form to the Employee Benefits Office, Heer Hall.

Employee signature Date

FOR BENEFITS USE ONLY

Verification of Eligibility:

___ One year service
___ Have completed Probationary Period (where appropriate)
___ No Disciplinary Action
___ No Worker's Compensation
___ No LTD coverage
___ 10 Day Eligibility Met: _____/_____/_____

Approver:

Employee Benefits Date