Department of
Human Resources

(601)979-2015
Fax No. (601)979-5856

DONOR/RECIPIENT LEAVE REQUEST FORM

I, _____ (Donor Employee, Please Print Name) , _____ (Employee J#), designate

to: _____ (Recipient Employee, Please Print Name) , _____ (Donor Employee, J#) - _____ (Personal Hours)

of my personal leave and/or _____ (Medical Hours) of my major medical leave.

As of date, I have a balance of _____ (Personal Leave) hours and a balance of _____ (Medical Leave) hours.

I donate these hours to be used for the catastrophic injury or illness to either the recipient for him/herself or his/her immediate family member requiring the services of a licensed physician for an extended period of time and that has forced the recipient employee to exhaust all leave time earned by that employee resulting in a loss of compensation. I understand that if the total amount of leave I have donated is not used by the recipient employee, the unused donated leave will be returned to me on a pro-rata basis, based on the ratio of the number of days of leave donated by each donor employee to the total number of days of leave donated by all donor employees.

Signature: _____ (Donor) Date: _____

Signature: _____ (Recipient) Date: _____

APPROVED:

Supervisor: _____ (Donor) Date: _____

Supervisor: _____ (Recipient) Date: _____

****ROUTE TO HUMAN RESOURCES FOR PROCESSING****

Revised 07/14