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(When filled in)

DMNA STATE LEAVE DONATION FORM

(Proponent is State Human Resources)

INFORMATION ABOUT DONOR

Name _____
Work Phone Number _____
Title _____
Agency _____
Salary Grade _____
Work Location _____
Negotiating Unit _____
ltem No. _____

For donors outside DMNA only:
Relationship to Recipient (check one) ☐ Relative ☐ Relative-ln-Law ☐ Person with whom I reside

INFORMATION ABOUT RECIPIENT

Name _____
Agency _____
Title _____
Work Location _____
Salary Grade Negotiating Unit _____

DONATION INFORMATION

Number of Vacation Days Donated _____

Authorization
I hereby authorize the Personnel/Payroll Office to deduct from my vacation balance the number of days indicated above to be used as sick leave by the recipient named above.
I certify that the days donated are not days I would otherwise forfeit and that this donation does not cause me to drop below a balance of ten days of vacation as of the date this donation is submitted.

Date _____ Signature of Donor _____

Certification by Agency Personnel/Payroll Office

(when donations are made to eligible family members in other agencies)
I certify that the donor is eligible to donate and that the above number of vacation days donated has been subtracted from the donor's vacation balance.
Name _____
Date _____

Signature _____
Title _____
Phone Number _____

Mail or fax this form to personnel/payroll office of recipient and retain a copy for donor's agency files.

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