LEAVE DONATION FORM

Print this form, fill out, sign and submit to your Personnel Department

DONOR INFORMATION

Name:	Title:	Salary Grade:

Negotiating Unit:	Payroll Item Number:	Social Security Number:	Work Phone Number:

Work Unit/Location:

RECIPIENT INFORMATION

Name:	Work Unit/Location:
Robert Lipiarz	Albion Correctional Facility 3595 State School Road Albion, NY 14411

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: