

Donating Shared Leave

Thank you for considering the donation of your earned leave to a fellow employee. Please review the following information before completing the donation form.

**Purpose**

The purpose of the shared leave program is to permit state employees to come to the aid of another state employee who:

1. Is or has a relative suffering from an extraordinary or severe illness, injury, impairment, or physical or mental condition; or
2. Is being called to service in the uniformed services, or
3. Is volunteering with a governmental or nonprofit agency when a state of emergency has been declared within the United States; or
4. Is the victim of domestic violence, sexual assault, or stalking; and…

Because of one of the above, the employee will take leave without pay or terminate employment.

**Donating Your Leave**

*Vacation:* You must retain a balance of at least 10 days (80 hours for full-time or pro-rated if part-time) of vacation/annual leave and may not contribute hours that you would otherwise be unable to use because of an approaching anniversary date.

*Sick Leave:* You must retain a balance of at least one hundred seventy-six (176) hours – not pro-rated for part-time employees.

*Personal Holiday:* All or a portion may be donated.

Direct questions to Payroll at 963-1202.

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| **CENTRAL WASHINGTON UNIVERSITY** **Shared Leave Donation Application****CWUP 2-30-060 Civil Service Employee Leave/** **CWUR 6-60-105 Shared Leave Use** |
| **Donating Employee:** Complete the following section and submit to your Department Head. |
| Name of Employee to Receive Shared Leave |
| Donor Name | Donor Employee ID# | Donor Telephone  |
| Donor Department | Donor Employment Status (Exempt, Civil Service, Faculty) |
| **Please reduce my leave balance(s) in the amount(s) indicated below, to be used as shared leave:** |
| Sick Leave: |  |
| Annual Leave: |  |
| Personal Holiday: |  |
| I voluntarily donate paid leave in the amounts specified, to the employee designated above. I have reviewed the information on the back of this form and request approval of my donation. I understand these donated hours will be deducted from my current leave balances and any Shared Leave not used by the receiving employee will be restored to me on a pro rata basis. |
| I do *[ ]*  or do not *[ ]*  consent to the release of my name, if requested. |
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| Signature of Donating Employee |  | Date |

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| **Department Head:** Complete the following section and submit to Payroll at mailstop 7425. |

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| Name | Mail Stop | Telephone |
|  |  |  |
| Department Head Signature |  | Date |
|  |  |
| ***For Use by Leave Administrator:*** |  |
| **Donor Leave Balances** | **Leave Balance Adjustment** |
| Annual Leave hoursSick Leave hoursPersonal Holiday hoursPercent of full-time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Full-time monthly salary: Anniversary Date:  | Annual Leave - hoursSick Leave - hoursPersonal Holiday - hours |
| **Donation:** *[ ]*  Approved *[ ]*  Disapproved | Adjusted for pay period:  |  |
|   |  |  | Adjusted by: |  |
| Leave Administrator |  | Date: | Date: |  |