

The Supreme Court of Ohio

**LEAVE DONATION PROGRAM – DONOR APPLICATION FORM
FOR PAYROLL PERIOD ENDING: _____**

I. DONOR INFORMATION

Donating Employee:

(Last)

(First)

Department: _____

Division: _____

Number of hours donated:

Type of leave donated:

____ Vacation

____ Sick leave

____ Personal leave

TOTAL HOURS DONATED

II. PERSON TO RECEIVE LEAVE

1. Use of donated leave is limited to 56 hours per pay period while awaiting disability benefits.
2. Donated leave may not be used to supplement state-paid benefit program(s) (e.g. disability leave, adoption/childbirth leave or workers' compensation)

Person to Receive Leave:

(Last)

(First)

Department: _____

Division: _____

III. CERTIFICATION

I hereby certify that this request is made voluntarily. I was not coerced, intimidated or financially induced into donating leave. By signing, I hereby relinquish all rights to the leave shown above and the benefits accruing to or attached to the same. I understand that the donation of leave is irrevocable and irreversible and that no leave will be refunded to me. I certify that I will have a remaining balance of 80 hours or more of combined leave (sick, vacation, personal and compensatory) after making this donation.

Date: _____

Signature of Donating Employee