

FAIRFAX COUNTY EMPLOYEE LEAVE DONATION FORM

DONATING EMPLOYEE

Complete and sign this form and forward all copies to the leave recipient's department head for processing. A copy will be returned to your department file after approval.

Your Name _____

EIN : _____

Department _____ Department Delivery Code _____

I authorize the transfer of my leave in the amount of: _____
Number of Hours

to the leave account of _____ for use as sick leave only.
Name of Employee

I wish to donate: Annual Leave Sick Leave
(If no box is checked, leave will be taken from Annual Balance.)

I understand that I relinquish all rights to the leave hours transferred and that I cannot recover these leave hours at a later date. I further understand that this leave will not be taken from my leave balance until the time that it is needed by the receiving employee.

Donating employee's Signature

Date