

UCOP CATASTROPHIC ILLNESS/INJURY LEAVE SHARING PROGRAM

Donor Form

Date: _____

Donor's Name (printed): _____ Employee ID # _____

Donor's Department: _____

1. Do you wish to donate vacation accruals to a designated individual? Yes No

If yes, to whom? _____

Recipient's Department _____

2. Do you wish to donate to the "UCOP Central Bank for Catastrophic Leave"? Yes No

3. Are you currently at maximum of your vacation accruals? Yes No

4. HOW MANY VACATION HOURS DO YOU WANT TO DONATE? _____

I certify that I am making this donation entirely of my own free will and that no attempts have been made to intimidate, threaten, or coerce me to donate my vacation hours. I understand that I have no right under any circumstances to have any of the donated hours restored to my accrued leave balance once I have signed this form and it has been approved by my division or department head. I further certify that this leave donation will not reduce my current leave balance by more than 50% and that, including this donation, I have not donated more than eighty (80) hours during the past twelve months.

Donor's Signature Date

Division or Department Head's (or designee's) Signature Date

Division or Department Head's (or designee's) Title

cc: Donor's Division/Department Timekeeper
Recipient's Division/Department Timekeeper (if applicable)
UCOP Human Resources (Benefit Services)
Payroll Services (UCLA Campus)