

FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT
DONATION OF SICK LEAVE PLEDGE FORM

In accordance with Article 10 of the Agreement between ACE and the District, I hereby authorize the following sick leave donation to (please type or print):

Name: _____

Campus: _____

Division: _____

I understand that I must retain a minimum of 60 days (480.00 hours) of sick leave and that I must donate sick leave in not less than 8-hour increments.

DONATING EMPLOYEE INFORMATION:

(Please type or print)

Name: _____ CWID _____

Campus: _____ Division: _____

Number of sick leave hours being donated: _____ Anonymouse Donation

Effective date of sick leave transfer: _____

Donating Employee's Signature: _____ Date: _____

Return This Form To:
Office of Human Resources
Foothill-De Anza Community College District
12345 El Monte Road, Los Altos Hills, CA 94022

For Office Use Only (initials of processor)

_____ Criteria Met _____ Balance of **donor's** sick leave before donation _____ Criteria Not Met

_____ Sufficient verification of certification for eligibility of **donee** _____ Not Sufficient

Donor's sick leave balance **decreased** to _____ hours by _____ effective _____

Donee's sick leave balance **increased** to _____ hours by _____ effective _____

Copy to Payroll Services on _____ by _____