ALCORN STATE UNIVERSITY
Alcorn State, Mississippi

DONATED LEAVE AUTHORIZATION

Date: _____

I, _____ Social Security No: _____
(Donor Employee)
designate to _____ Social Security No: _____
(Recipient Donor)
_____ hours of my personal leave and/or _____ hours of my major medical leave. According to the Office of Human Resources, I have a balance of _____ hours personal leave and a balance of _____ hours major medical leave, as of period ending _____.

(Note: Leave donated must be in 24-hours increments. The 24-hours may be a combination of personal and major medical leave.)

I donate these hours to be used for the catastrophic injury or illness to either the recipient employee or his or her immediate family requiring the services of a licensed physician for an extended period of time and that has forced the recipient employee to exhaust all leave time earned by that employee resulting in a loss of compensation. I understand that if the total amount of leave I donate is not used by the recipient employee, the donated leave will be returned to me on a pro-rata basis, based on the ratio of the number of days of leave donated by each donor employee to the total number of days of leave donated by all donor employees.

Donor's Signature: _____ Date: _____

Approved by:

_____ Date: _____
(Donor's Department Head/Supervisor)

Note:

Catastrophic injury or illness is defined as a life threatening injury or illness which totally incapacitates the individual or the employee from work. Conditions that are short-term in nature, including, but no limited to, common illnesses such as influenza, and the measles, and common injuries ARE NOT catastrophic. Chronic illnesses or injuries, such as cancer or major surgery, which result in intermittent absences from work and which are long-term in nature and require long recuperation periods maybe considered catastrophic.

(Note: Eligible family member means: spouse, parent, step parent, sibling, child or stepchild.)

Approved by:

_____ Date: _____
(Recipient's Department Head/Supervisor)

_____ Date: _____
Director of Human Resources

(**To be completed by Human Resources only**)

Recipient did not use all of the donated leave. Consequently, donated leave is being returned to the donor in the amount of:

Major Medical _____ hours Personal _____ hours

(5/2003)