SICK LEAVE DONATION AGREEMENT

I, _____, _____, employed by
Donating Employee's Name Social Security Number

_____ wish to donate _____ hours of sick
Donating Employee's Agency

leave to _____, _____,
Employee To Whom Donating Leave Social Security Number (if Known)

Employed by _____.
Receiving Employee's Agency

I understand the I must agree to donate a minimum of five (5) days of sick leave (37.5 hours for employees on a 7.5 hour per day work schedule or 40.0 hours for employees on a 8 hour per day work schedule) and that I may not donate more than one-half of my sick leave balance in effect at the point leave is first deducted from my balance. I also understand that I may not donate more than a total of ninety (90) days of sick leave during my employment with the State of Tennessee.

I am donating this leave of my own free will and understand that sick leave deducted from my leave balance may not be returned.

_____ _____
Signature Date

1._____ _____
Witness Date

2._____ _____
Witness Date

_____ _____
Personnel Officer's Signature Date