

**THE COLLEGE OF NEW JERSEY
DONATED LEAVE PROGRAM**

Donor Transfer Certification

I hereby authorize The College of New Jersey to transfer leave credit as indicated below to be used as the recipient's personal sick leave.

DONATION SECTION:

DONATE TO: _____
(Please print full name of recipient)

I wish to donate the following:

_____ SICK DAYS - I certify that my sick leave balance will not be less than
(number) 20 accrued sick days after this transfer.

_____ VACATION DAYS - I certify that my vacation leave balance will not
(number) be less than 12 accrued vacation days after this transfer.

_____ TOTAL DAYS DONATED* - (Cannot exceed 10 days per recipient)
(number)

*Donation of less than 5 days will result in conditional approval until minimum of 5 days has been donated to the recipient.

CERTIFICATION SECTION:

I certify that I have not been coerced nor solicited or accepted anything of value for the donation of paid leave time.

_____ Date _____ Print Name _____ Signature

Dept.: _____ Office Phone: _____

RETURN TO: OFFICE OF HUMAN RESOURCES, ADM. SERVICES BLDG.

FOR USE BY THE OFFICE OF HUMAN RESOURCES

_____ Transfer Approved _____ Transfer Disapproved

This is to advise you your request to donate leave time cannot be accepted due to the following reason(s):

_____ Recipient is no longer active.

_____ Employee has already received the maximum number of donated days.

_____ Your current sick balance does not show the required minimum number of
20 accrued days.

_____ Your current vacation balance does not show the required minimum number of
12 accrued days.

_____ Other _____

_____ Appointing Authority Signature _____ Date