

LEAVE TRANSFER REQUEST AND AUTHORIZATION

(Please return completed form to Bethany Rogers in Human Resources)

Name of Donor: _____

Building: _____

Signature: _____

Date: ____ / ____ / ____

Under provision of [WAC 41.04.665](#), I am requesting that you transfer _____ hours of my disability/sick leave to:

(Name of receiving employee)

I wish my donation to be confidential: Yes No

Employees must maintain 176 hours of disability/sick leave to donate.

.....

PAYROLL/HUMAN RESOURCES USE

_____ Number of hours transferred

_____ Approval of Human Resources

Other Factors:
