New York State Education Department
Office of Human Resources Management
89 Washington Avenue, Room 528 EB, Albany, NY 12234
Phone (518) 474-5215 - - Fax (518) 486-5631

# REQUEST TO PARTICIPATE IN LEAVE DONATION PROGRAM

| Employee Name | |
|---|---|
| Social Security Number | Percent Worked |
| | ☐ 100% ☐ VRWS____% ☐ Part-time____% |

☐ I wish to participate in the Leave Donation Program.

☐ I wish to have my name listed on the Human Resources Web Site.

☐ I do not wish to have my name listed on the Human Resources Web Site.

☐ I wish to use donated leave credits after the exhaustion of all leave credits and prior to sick leave at half-pay.

_____ is the date my leave credits will be exhausted at the close of business.
(Date)

☐ I wish to use donated leave credits after the exhaustion of all sick leave at half-pay.

At that time, I wish to use donated credits in:

☐ Half-day units.

☐ Full-day units.

_____ _____
Signature Date

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