



PINAL COUNTY LEAVE DONATION FORM

I voluntarily request to donate leave to (Print Name): _____
 I understand that I may not revoke this donation once it has been credited to the recipient's leave balance. I further understand that the leave I have donated will be deducted from my available balance in the pay period it is needed by the Donor, in sufficient quantity to ensure the Donor receives a full paycheck.

Donor Name:	Donor Employee #:	Donor Department:
Donor Signature:	Date:	
Vacation Hours Donated:	Compensatory Time Donated:	
Subscribed and sworn before me this _____ day of _____, 20 _____.		
_____ Notary Signature		

Donor employee has a minimum of 80 hours of vacation time remaining?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Charge Donation to Donor: <input type="checkbox"/> Donor <input type="checkbox"/> Recipient <input type="checkbox"/> Department	Donor Department Approval:	Date:

RECIPIENT DEPARTMENT VERIFICATION

Recipient Name:	Recipient Employee #:	Recipient Department:
Recipient Contact Phone #: ()	Recipient Start Date:	
Recipient employee is a regular status employee?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Recipient employee has a serious health condition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Recipient employee has exhausted all Sick, Vacation, and Compensatory Time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Recipient employee is eligible for FMLA, and has completed the "Certificate of Health Care Provider" form?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Recipient Appointing Authority Approval:	Date:	

===== **TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT** =====

Employee able to receive benefits?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• Through a disability insurance program obtained through Pinal County	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• From the retirement system of which they are a member.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• From Social Security.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• From a publicly funded financial assistance program for disability including Workman's Comp.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Approved:	Charge to: Donor <input type="checkbox"/> Recipient <input type="checkbox"/>	Date:
Not Approved:	Date:	
Reason:		
Calculated by:	Sick hours credited:	