Human Resource Services
Time & Attendance/Leaves

LEAVE DONATION PROGRAM – DONOR

Employee Name: ____

Title: ____

Stony Brook Employee ID #: ____

Line Number: ____

Salary Grade: ____

Department: ____

Work Telephone Number: ____

RECIPIENT

Information about the person to receive the donation

____
____
Name
Department

DONATION

____________________ Number of Vacation Days Donated

AUTHORIZATION:

I hereby authorize Human Resource Services – Time & Attendance to deduct from my vacation balance the number of days, as indicated above,

to be used as sick leave by the recipient named above. I certify that the days donated are not days I would otherwise forfeit and that this donation does not cause me to drop below a balance of ten days of vacation as of the date this donation is submitted.

____
____
Donor's Signature
Date

STONY BROOK, NEW YORK 11794-0751 Tel: 631-632-6189 FAX: 631-632-4989