ALLEGANY · COUNTY ·
Department of Human Resources

CONFIDENTIAL

ALLEGANY COUNTY GOVERNMENT
SICK LEAVE DONATION AGREEMENT

I, _____, _____,
Donating Employee's Name Employee Number

Employed by Allegany County Government wish to donate _____days of sick leave to

_____, _____.
Employee To Whom Donating Leave Employee Number

I understand the following:

1. I may not donate mare that five (5) days or forty (40) hours of sick leave per fiscal year.
2. I agree that any unused sick leave which I have donated to the employee stated above will be transferred back to my sick leave balance.

I am donating this leave of my own free will and have not been unduly influenced in any manner to make this contribution.

_____ _____
Donator's Signature Date

FOR OFFICE USE ONLY (Record all data in hours).

Date certification of recipient's disability was received: _____

Donor's sick leave balance as of _____: _____
Date to be transferred _____
Donor's balance at time of transfer: _____
Number of hours transferred: (Maximum of 40 per Fiscal Year) _____
Prior number of hours donated: _____

Approved: _____ _____
Director of Human Resources Date

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