Port Townsend School District #50

1610 Blaine St
Port Townsend WA 98368
Human Resources Office: (360) 680-5755

Shared Leave Donation Form

TO: HUMAN RESOURCES OFFICE

FROM: NAME _____
(Please print name of employee)

LOCATION _____

RE: APPLICATION FOR SHARED LEAVE

Under the provision of Board Policy No. 5406/5406P, I request that you authorize me to transfer

_____ days of my sick leave, or

_____ days of my annual "vacation" leave to:

_____
(Name of Employee Beneficiary)

I am aware that I must retain a minimum balance of twenty-two (22) days of sick leave and ten (10) days of annual "vacation" leave to be eligible to participate in the shared leave program. I have read and understand the criteria which will be used in determining my eligibility to participate and how it may affect all my leave balance.

_____ _____
(Employee's Signature) (Date)

For Office Use Only:

☐ Request Granted

☐ Request Denied

Reason for Denial: _____

_____ _____
(HR OFFICE) (Date)

SICK LEAVE		"VACATION" LEAVE	
Beginning Balance	_____	Beginning Balance	_____
Days Donated	_____	Days Donated	_____
Ending Balance	_____	Ending Balance	_____

(Payroll) _____
(Date) _____

CREDIT

Leave Not Used (Days): Return Credit _____

Adjusted Leave Balance _____
Date Leave Adjusted _____

(HR) _____
(Date) _____