Stony Brook Medicine

University Hospital Finance Timekeeping Department

LEAVE DONATIONS FORM

Robert Jacobsen _____ _____

NAME OF RECIPIENT EMPLOYEE **DAYS DONATED**

_____ _____

Name of Donor (Please Print) **Title of Donor Employee**

_____

Donor Emp Id Number **Donor Line Number** **Donor Employee Work Number**

I HEREBY AUTHORIZE THE TIMEKEEPING DEPARTMENT TO DEDUCT FROM MY VACATION BALANCE THE NUMBER OF DAYS INDICATED ABOVE TO BE USED AS SICK LEAVE BY THE RECEPIENT ABOVE. I CERTIFY THAT THE DAYS DONATED ARE NOT DAYS I WOULD HAVE OTHERWISE FORFEITED AND THAT THIS DOCUMENTATION DOES NOT CAUSE ME TO DROP BELOW A BALANCE OF TEN **(10)** DAYS OF VACATION AS OF THE DATE THIS DOCUMENTATION IS SUBMITTED.

_____ _____

Date **Signature of Donor Employee**

FAX TO 444-5822

Timekeeping Department use only

Verification of days Yes___ No____ _____

Timekeeper Signature

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