THE UNIVERSITY OF TEXAS AT DALLAS

EMPLOYEE-TO-EMPLOYEE SICK LEAVE DONATION

To be Completed by The Donor

Donor's Name: _____Employee ID: _____

Recipient's Name: _____ Employee ID: _____

In accordance with the employee to employee leave donation rules, I (donor) _____ hereby donate _____hours of sick leave to be used by _____ (recipient). By signing this form, I understand and agree to the following statements:

- I agree this is a voluntary contribution.
- I understand the number of sick leave hours donated will be deducted from my own sick leave balance.
- I understand the hours I donate will no longer be available for my use.
- I understand any unused hours by the recipient will not be returned to my available sick leave balance.
- I understand I am responsible for maintaining a sufficient sick leave balance for my own absences.
- ***I understand taxation related to the employee to employee sick leave donation will be consistent with the Internal Revenue Service and UT System Guidelines and any other laws that this may impact.***
- I attest I have not been directly or indirectly been intimidated, threatened, or coerced by any person or persons in connection with this leave donation.
- I attest I have not and will not receive any financial payments, gifts, favors, or special treatment in exchange for this donation.
- I agree to hold confidential any medical or personal information shared with me by the recipient.
- I attest that this is a true and accurate representation of the facts.
- I understand any misrepresentation of the facts could be subject to disciplinary action, up to and including termination of employment.

_____ _____ _____

Donor Signature | Printed Name of Donor | Date

By checking this box you are requesting to have your donation remain anonymous ☐

Once sick leave donations are approved, recipients will receive the name of the donor unless otherwise specified above.

To be completed by the Office of Human Resources

I certify the above named recipient is eligible to receive sick leave donation.

_____ _____

Leave Administrator (Signature) | Date

I certify that this contribution has been deducted from the donor's sick leave balance and credited to the recipient's sick leave balance.

_____ _____

Benefits Analyst (Signature) | Date

Revised 5/24/16