BOARD OF REGENTS OF
THE UNIVERSITY SYSTEM OF GEORGIA

SHARED SICK LEAVE PROGRAM - ENROLLMENT FORM

Institution Name: _____ Department: _____

Employee Name: _____ Employee ID: _____

Phone #: _____ Email: _____

Hire Date: _____ Supervisor: _____

I have successfully completed my provisional period: ☐ Yes ☐ No

I wish to donate _____ hours of sick leave (8 hour minimum and 80 hour maximum) (pro-rated for part-time employees) to be used as part of the Shared Sick Leave Program. The leave will be transferred to the sick leave pool effective January 1st, unless otherwise notified. Enrollment Date:_____

I hereby acknowledge the following:

- I agree that my donation is strictly voluntary.
- I understand that I must donate a minimum of eight (8) hours and retain at least 40 hours of sick leave in my own account when donating sick leave. Hours are pro-rated for part-time employees.
- I agree that the hours that I am donating have already been accrued.
- I understand that after my leave donation has been charged against my leave balance, it is irrevocable and cannot be withdrawn.
- I understand that if the leave pool is depleted, I will be notified and automatically charged eight (8) hours, unless I wish to withdraw at that time.

I have read and understand the policies related to the **Shared Sick Leave Program** and agree to participate by signing my name and dating below.

Employee Signature: _____ Date: _____

INSTRUCTIONS: Please complete and return this Shared Sick Leave Enrollment form to your Office of Human Resources

FOR USE BY THE OFFICE OF HUMAN RESOURCES

☐ Leave Donation Approved ☐ Leave Donation Denied Effective Date of Leave Transfer _____

Denial reason and/or comments:

_____

_____

_____

Signature of Program Administrator: _____ Date: _____