

**Catastrophic Leave-Sharing Program**  
**RECIPIENT PARTICIPATION REQUEST**  
*Residential and Student Service Programs*

Recipient's name \_\_\_\_\_

Unit \_\_\_\_\_ Date of hire \_\_\_\_\_ Career or Casual? \_\_\_\_\_

The dates of your expected period of leave are: \_\_\_\_\_

Before you can accept any donations of vacation leave, this program requires that you exhaust all accrued sick leave, vacation, and compensation time. After all accruals are used, approximately how many hours would you need to cover your approved period of leave? \_\_\_\_\_ (Must be at least 8 hours)

Will donation be used for yourself or a family member? If family member, please provide relationship.

\_\_\_\_\_

The program requires that donations be approved on the basis of a "serious health condition" (see program information for definition).

Briefly explain what the "serious health condition" is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please read the following statements then sign below to acknowledge that you understand and accept these conditions.**

*I, the recipient understand that the number of hours donated were converted to actual hours of vacation leave based on the donor's and my individual pay rates. If the hours donated are different than I anticipated, it is because both my pay and benefits rates were converted into the donor's pay rate only.*

*I, the recipient understand that I have sole responsibility for assessing the potential impact of this donation on my taxes and benefits.*

PLEASE CHECK ONE:

- I accept these conditions and this donation of hours.
- I do not wish to accept this donation.

\_\_\_\_\_  
Recipient's approval to accept donation

\_\_\_\_\_  
Date

*Please return completed request form in an envelope marked confidential to:*

**Letrice Thomas  
Housing and Dining Services  
Payroll and Benefits Office  
2535 Channing Way, MC 2272**