



Vacation Donation Recipient Agreement Policy 2.6.40 Paid Leave Human Resources

Recipient Information

Name: _____ FTE: _____

Department: _____ Title: _____

Current leave balances: Sick _____ Vacation _____ Compensatory _____

I am accepting _____ hours of donated vacation time.

Recipient Statement of Understanding

I certify that I am not currently receiving any paid benefit as a result of my employment with the college, such as Long-Term Disability or Worker’s Compensation. I understand that I am not eligible to simultaneously receive LTD and/or Workers’ Compensation while receiving pay from this donated time. I understand that converted sick hours paid to me will not exceed my normally scheduled work hours per pay period and will be counted concurrently as Family Medical Leave, if applicable. Additionally, I understand that compensation received under the Vacation Donation Program is considered taxable income.

Recipient Signature *Date*

Office of Human Resources Signature *Date*

Approval

Recipient Department Head Signature *Date*

Executive Leadership/President *Date*