



SICK TIME DONATION REQUEST FORM

Donor Information

Employee Name	
Employee Identification Number	
Job Title	
HR Organization (Number & Name)	

Recipient Employee Information

Employee Name	
Employee Identification Number	
Job Title	
HR Organization (Number & Name)	

Total number of HOURS being donated: _____

Certification of Recipient Employee

I do hereby certify that I have secured permission from my Employment Unit to use donated sick time pursuant to policy. This request is supported by documentation on file with Employee Health, in order to continue my compensation. My benefit time accrual balance (sick leave, vacation time, and personal holidays) is less than or equal to 40 hours prior to this request.

Have you applied for, or do you plan to apply for, Retirement Due to Disability? ☐ Yes ☐ No

Recipient Employee's Signature _____ Date ____/____/____

Certification of Donating Employee

I do hereby certify in making this voluntary donation that my Employment Unit has permission to transfer the number of hours of my sick time listed above to the Recipient Employee. I understand that my sick time balance will be reduced by the specified number of hours. I further understand the impact of sick time on creditable service with the Teacher's Retirement System of Alabama and that this decision is irrevocable as of the date this form has the required signatures. I further understand that I must maintain a specified amount of sick time for my own use as outlined in the Sick Time Donation Policy.

Have you applied for retirement based on years of service? ☐ Yes ☐ No - If Yes, Date of Retirement _____ Date ____/____/____

Donating Employee's Signature _____ Date ____/____/____

Certification of Recipient's Dean or Director or Department/Unit Head

I do hereby certify for the Recipient Employment Unit listed above that this request meets the guidelines for donating sick leave pursuant to policy and established procedures. I acknowledge receipt of the donated hours and understand that the total hours donated above will be added to the Recipient Employee's sick time record.

Recipient's Dean or
Director or Department/Unit Head _____ Date ____/____/____

Approved / Denied:

Office of Human Resources - Records Administration Date ____/____/____

Date Accruals Entered ____/____/____

**Send completed form to: HR Records, AB 254 or email to Leave@uab.edu. HR Records Administration will adjust the donor and recipient records to reflect the new balances.*