HUMAN RESOURCES DEPARTMENT
STAFF LEAVE DONATION REQUEST FORM

Name: _____ (Please Print)	**Hospital ID A#:** _____
Department: _____	**Office No.:** _____
Title: _____	**Date of Hire:** _____
Date of Request:_____	

Please indicate briefly why you are requesting to be in the Staff Leave Donation Program

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For a donation of sick time to be approved, the conditions for Recipient and Donor must be met as specified in the Staff Leave Donation Policy.

Staff Leave Donation Administrative Guide and Policy are available online at http://www.uhnj.org/hrweb/policies/Sick%20Leave%20Donation%20Program.pdf .

Please feel free to contact Brianna Holman at myloa@uhnj.org should you have any questions or need assistance.

_____ _____
Employee Signature **Date**

_____ _____
Benefits Representative **Office Telephone No.**