

**SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
LEAVE POOL DONATION FORM**

Employee Section:

Name: _____

Personnel Number: _____

Division/Regional Center/Central Office: _____

Hours Donated: _____ Annual Leave _____ Sick Leave

Employee Signature: _____ Date: _____

An employee may not donate more than one-half of the sick or annual leave they earn within a calendar year to the appropriate Leave Pool. However, an employee who donates sick leave must retain a minimum of 15 days sick leave.

If you are requesting to donate leave to a specific employee, please complete the following:

Name of employee: _____

Job Title: _____

Location: _____

Human Resources Section:

Class Title: _____ Class Code: _____

Annual Salary: _____ Hourly Rate: \$ _____

Annual Leave:

Monthly Accrual Rate/Hours: _____

Total Annual Accrual Rate/Hours: _____

Maximum Allowable Donation: _____

Balance at Effective Date: _____

Hours Donated: _____

Monetary Value: _____

Sick Leave:

Monthly Accrual Rate/Hours: _____

Total Annual Accrual/Hours: _____

Maximum Allowable Donation: _____

Balance at Effective Date/Hours: _____

Hours Donated: _____

Monetary Value: _____