EMPLOYEE SICK LEAVE TRANSFER PROGRAM (ESLTP)

Sick Leave Transfer Authorization

Name: _____

Date: _____

Full-Time Employee: ☐ YES ☐ NO

Work Site: _____

Number of Days Transferred: _____ (donor must maintain 10-day balance)

Name of Recipient: _____

Employee Signature: _____

Payroll Verification: _____

Human Resources Approval: _____