

MISSISSIPPI DEPARTMENT OF EDUCATION
DONATION OF LEAVE FOR CATASTROPHIC ILLNESS OR INJURY

I, _____, hereby request that _____ hours of
(Name of Donor Employee) (Must be at least 24 hours)

personal leave or _____ hours of major medical leave presently credited to my account
(Must be at least 24 hours)

be donated upon receipt of this signed form to _____
(Name of Recipient Employee)

employed by _____
(Name of Agency)

(Signature of Donor Employee)

(Date Signed)

(Signature of Immediate Supervisor)

(Date Signed)

(Approval by Office of Human Resources)

(Date Signed)

(Signature of Accounting Staff)

(Date Signed)