Form 25A
June 2007

STATE OF ALABAMA
PERSONNEL DEPARTMENT
REQUEST TO DONATE LEAVE

	Beneficiary Employee Information	**Donating Employee Information**
Employee Name		
Social Security Number		
Class Code/ Pay Range	/	/
Department/Division	/	/

Donated Leave Dates: From _____ Through _____

Sick Hours _____
Annual _____
Comp _____

Catastrophic Illness/Injury:

Certification of Donating Employee:

I do hereby certify that I am making this request to donate leave to the Beneficiary Employee listed above voluntarily and without coercion or other improper means. I further certify that my agency has permission to donate the above listed hours of my leave to the Beneficiary Employee listed above. I understand my leave balance will be reduced by the number of hours used should my leave be necessary for the beneficiary's illness/injury as shown above.

Donating Employee _____ Date _____

Certification of Donating Employer:

I do hereby certify that the donating employee's information listed above is correct and that this request meets the requirements of Code of Alabama §36-26-35.2 (2001).

Donating Appointing Authority _____ Date _____

Acceptance by Beneficiary Employer:

I do hereby certify for the Beneficiary Agency listed above that this request meets the guidelines for donating leave provided in Code of Alabama §36-26-35.2 (2001) and established procedures. I authorize my agency to add the total hours donated above to the Beneficiary Employee listed.

Beneficiary Appointing Authority _____ Date _____

Approved:

Personnel Director _____ Date _____