# Abraham Baldwin Agricultural College

## Shared Leave Program Membership Form

**Name of Donor:** _____ **Effective Date:** _____

**Faculty**_____**Staff** _____

**Department:** _____

**Email Address:** _____

**Telephone Number:** _____

I wish to become a member of the Shared Leave Program.

In doing so,

- I understand that I must be in a benefitted position at Abraham Baldwin Agricultural College that accrues sick leave.
- I must initially, voluntarily contribute as a one-time membership minimum of one (1) day or eight (8) hours of sick leave.
- **Donation: Sick Leave Hours**_____
- In order to remain an active participating member, I must voluntarily contribute an additional eight (8) hours of sick leave per calendar year to be taken out every participating year on December 31.
- I understand and agree that Abraham Baldwin Agricultural College may request of me to donate a maximum of one (1) additional day or eight (8) hours to the Leave Bank if at mid-year assessment the Bank reserve falls below 320 hours. This request may only be done once a year.
- I understand and agree that leave donations to the Bank are non-refundable, non-transferable and **cannot be withdrawn**.
- I will abide by the Shared Leave Program policy.

Signature of Donor: _____ Date:_____

For Use By the Abraham Baldwin Agricultural College's Human Resources Leave Administrator.

Transfer Approved:_____Transfer Not Approved: _____

This is to advise you that your request to join Abraham Baldwin Agricultural College's Shared Leave Program cannot be accepted due to the following reason(s):

_____

_____

_____

Signature of Leave Administrator: _____ Date:_____