**CATASTROPHIC LEAVE DONOR AUTHORIZATION**

TO BE COMPLETED BY DONOR

|  |
| --- |
| **DONOR INFORMATION** |
| Employee Name: |  |  | UW Institution: |  |
| UW System Title: |  |  | Department: |  |
| Working Title: |  |  | FTE %: |  |
| E-mail address: |  |  | Supervisor: |  |
|  |
| **RECIPIENT INFORMATION** |
| Employee Name: |  |  | UW Institution: |  |
| UW System Title: |  |  | Department: |  |
|  |
| **DONATION** |
| Type and amount of LEAVE to be transferred *(full hour increments only)* |
| Vacation: |  |  |
| Personal/Floating Holiday: |  |  |
| ALRA/Sabbatical: |  |  |
|  |
| I authorize the transfer of the paid leave hours to the above named recipient.  |
| I wish to keep my donation confidential: [ ] Yes [ ]  No |
| Employee Signature:  |  | Date:  |  |
|  |
| **FORWARD TO HUMAN RESOURCES FOR PROCESSING**  |