

**ALVORD UNIFIED SCHOOL DISTRICT**  
**CLASSIFIED CATASTROPHIC LEAVE**  
**DONATION FORM**

I understand that this donation of my sick leave is made specifically for the following unit member: \_\_\_\_\_ (name of the person to receive the donation).

Further, I understand that this donation will be deducted from my accumulated sick leave. I also understand that, upon retirement, I shall not be entitled to receive credit for the day(s) donated once the days have been received by the person to whom they were donated.

My signature below indicates my agreement to hold the District and the California School Employees Association harmless for all claims and liabilities arising from my donation.

- I wish to donate \_\_\_\_\_ (number of days, *maximum eight*)

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 201\_\_\_\_\_

\_\_\_\_\_  
Name – please print

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
School Site

**(RETURN THIS FORM TO THE DISTRICT PAYROLL OFFICE)**

Payroll Office Verification:  8 days deduction  5 days deduction  2 days deduction  
 7 days deduction  4 days deduction  1 day deduction  
 6 days deduction  3 days deduction  None

Notes: \_\_\_\_\_  
\_\_\_\_\_

Copies: Payroll (white) /Association (yellow) /Human Resources (pink) /Donating Employee (goldenrod)

**DO NOT SEPARATE COPIES – PAYROLL WILL DISTRIBUTE**