WENATCHEE VALLEY COLLEGE

**FOSTER PARENT SHARED LEAVE POOL DONATION FORM**

**NOTE:** This form is only used if an employee wishes to irrevocably donate leave to the state’s Foster Parent Shared Leave Pool. Leave from the Foster Parent Shared Leave Pool can be requested from any eligible state employee who is caring for a foster child or is preparing to care for a foster child.

Donor employee completes Section I; department completes Section II; HR Office completes Section III

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| **PART 1 – Donor Information: *Complete this section and forward the completed form to your department administrator for approval*** | | | | | | | | |
| Donor Employee Last Name: | | First Name: | | | | MI: | | |
| Donor WVC SID: | Donor Anniversary Date (Time Off Service Date): | | Donor Department: | | | | | |
| Donor Work Phone: | Donor Email: | | | | Donor Monthly Salary: | | | |
| I voluntarily donate the following total time off hours to the Washington State Foster Parent Shared Leave Pool and request departmental approval. I understand that these donated leave hours will be permanently deducted from my current, appropriate leave balance(s).  **Total Time Off Hours Donated**: Hours (must be the same as “Total Hours Donated” Box below)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Donor Signature Date | | | | | | | | |
| **Vacation Time Off** | | | | **Donor Completes** | | | **Leave Recorder Completes** | |
| **DONOR EMPLOYEE:** Complete this section to donate **vacation time off** hours to a designated state employee to be used as shared leave. You may donate a minimum of four (4) hours but you may not donate vacation hours which would reduce the balance to less than eighty (80) hours for full time employment; prorated for part time employment. Also, you may not donate any excess vacation hours above the 240 maximum that you would otherwise be unable to use because of an approaching anniversary date. | | | | VAC Hours Donated | | | Current VAC Hours | VAC  Balance After Donation |
| **Sick Time Off** | | | |  | | |  | |
| **DONOR EMPLOYEE:** Complete this section to donate **sick time off** hours to a designated state employee to be used as shared leave. You may donate a minimum of four (4) hours but you may not donate sick leave hours which would reduce the balance to less than 176 hours (154 for faculty). | | | | SICK Hours Donated | | | Current SICK Hours | SICK  Balance After Donation |
| **Personal Holiday** | | | |  | | |  | |
| **DONOR EMPLOYEE:** Complete this section to donate your **personal holiday** hours to a designated state employee to be used as shared leave. You may donate a minimum of four (4) hours. Unused personal holiday hours will be restored only if returned within the same calendar year. | | | | PH Hours Donated | | | PH Hours Available | PH Balance After Donation |
| **ALL DONATED HOURS WILL BE DEDUCTED FROM THE APPROPRIATE LEAVE BALANCE(S)** | | | | Total Hours Donated | | |  | |

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| **PART 2 – Department: To be completed by donor department** | | | | | | | |
| If you approve the hours donation, please verify hours and remaining balances, complete this section and the “Leave Recorder” portions of Part 1 of this form, and send all parts to your HR office.  **Prior approval by the organization budget authority is required where a charge transfer is involved.** | | | | | | | |
| Budget Name: | | |  | | | | |
| Budget Number to be Charged: | | % Distribution | |  | |  |  |
| Budget Number to be Charged: | | % Distribution | |  | |  |  |
| Budget Number to be Charged: | | % Distribution | |  | |  |  |
| Name of Department Contact Responsible for Maintaining Absence Record: | Contact Phone: | | | | Contact Email: | | |
| **The donating employee meets the eligibility requirements stated above in Section 1. I approve this request to donate leave hours and verify that sufficient funds are available to cover the charge transfers.** | | | | | | | |
| Name of Administrator or Manager (please print or type):  Date:  Signature | | | | | | | |
| Name of Budget Authority (please print or type):  Date:  Signature | | | | | | | |

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| **PART 3 – HR Office: To be completed by HR office** | | |
| The cash value of these hours will be credited to the Washington State Foster Parent Shared Leave Pool. As applicable, this amount will be charged to your department budget as it is used by the designated employee. | Vacation Hours | The above-named employee is eligible to donate time off effective:  Date: |
| Sick Hours |
| Personal Holiday Hours |
| **HR Office Approval**  Date:  Signature | | Phone: |