



LEAVE DONATION REQUEST FORM

Employee Name: _____

Date: _____

Employee's ID Number: _____

Employee's Supervisor: _____

I wish to request donated time from the Leave Donation Program. I understand that it is not a guarantee that I will receive donated time and that I can receive no more than 6 weeks of donated time (30 days) over a rolling 12 month period.

My request is due to experiencing one of the following situations:

- I have been unable to work remotely due to a major disaster (COVID is considered one of several major disasters).
- I have experienced a family medical emergency that requires instant care and a prolonged/extended absence from work.

With my signature below, I understand that:

- I have at least 1 year of MBI service in a full-time position.
- I have exhausted all of my accumulated annual sick, personal, and vacation time, and I am currently unable to work due to a major disaster or family medical emergency.
- The donated time that I receive will be considered wages, and I will be taxed accordingly.

Employee Signature: _____

Date: _____

Human Resources Approval: _____