

**North Georgia Health District  
CBH LEAVE DONATION AUTHORIZATION**

**SECTION I: *To be completed by the donor***

In accordance with the Leave Donation policy, I donate (in whole 8 hrs increments):

\_\_\_\_\_ hours of my annual leave  
\_\_\_\_\_ hours of my personal leave  
\_\_\_\_\_ hours of my sick leave

to be used by \_\_\_\_\_  
Name of Employee (Recipient) Work Location

I understand that the above amount(s) of donated leave will be deducted from my accrued annual, and/or personal, and/or sick leave balance(s) and will not be available for my use.

\_\_\_\_\_  
Printed Name of Donor Work Phone # Employee ID #

\_\_\_\_\_  
Employer (Specify County Board of Health)

\_\_\_\_\_  
Signature of Donor Date

**This donation will not be processed without a signature.**

\*\*\*\*\*

**SECTION II: *To be completed by the personnel representative***

Leave Balance(s) AFTER Donation

\_\_\_\_\_  
Date & Time Received by Personnel Representative Annual \_\_\_\_\_  
Personal \_\_\_\_\_  
Sick \_\_\_\_\_

\_\_\_\_\_  
Signature of Personnel Representative Date

Amount of Leave Donated: \_\_\_\_\_ Hrs. Annual \_\_\_\_\_ Date Donated  
\_\_\_\_\_ Hrs. Sick \_\_\_\_\_ Date Donated  
\_\_\_\_\_ Hrs. Personal \_\_\_\_\_ Date Donated

Amount of Leave Returned: \_\_\_\_\_ Hrs. Annual \_\_\_\_\_ Date Returned  
\_\_\_\_\_ Hrs. Sick \_\_\_\_\_ Date Returned  
\_\_\_\_\_ Hrs. Personal \_\_\_\_\_ Date Returned