SHARED SICK LEAVE PROGRAM - ENROLLMENT FORM

Institution Name: ______________________________ Department: _________________________________

Employee Name: _______________________________ Employee ID: _________________________________

Phone #: _________________________________ email: _______________________________________

Hire Date: _________________________________ Supervisor: ___________________________________

I have successfully completed my provisional period: Yes No

I wish to donate __________ hours of sick leave (8 hour minimum an754( )]TJETBT1 0 0 1 85.7 0 (RA)-(M4( )]TJETBT1 40 451 18

Signature of Program Administrator: ____ Date: ____________