



# Shared Leave Pool Form

**Averett  
University**

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## Shared Leave Pool (SLP) Membership Form

**Date:** \_\_\_\_\_ **Amount of Leave Donated:** \_\_\_\_\_ (Hours)

**Name:** \_\_\_\_\_

**People ID #:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Department:** \_\_\_\_\_

**Date of Employment:** \_\_\_\_\_

I have read the Shared Leave Policy and understand all the requirements to become a member of this program. I agree to donate 16 hours of sick leave at this time and an additional eight hours if requested by the vice president of human resources (VP of HR) and the benefits coordinator (BC). I understand that if my employment is terminated for any reason or I retire, I cannot continue to be a member of this program and receive benefits.

**Donor Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

I have exceeded the amount of accrued sick leave allowed by the University and elect to donate any additional accrued hours to the SLP each pay period. This will remain in effect until a revised membership form is completed and returned to the benefits coordinator.

**Donor Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_