Ensure that the most current form is submitted. Refer to EMACS Forms/Procedures website.

MEDICAL EMERGENCY LEAVE (MEL)
AGREEMENT TO DONATE LEAVE TIME

CONFIDENTIAL

Must print in Black or Blue ink ONLY

DONOR

Employee ID	Rcd No.	Last Name, First Name	
Position No.	**Company**	**Department**	**Telephone**

I wish to donate the following type and number of accrued leave hours to the employee (recipient) named below.

I understand, per fiscal year, my total donation of available leave hours may be donated only in eight (8) hour increments and may not exceed a total of 50% of my annual accrued vacation, administrative, annual, attorney or compensatory time.

I also understand, per fiscal year, I can donate four (4) hours of holiday time, which is 50% of my annual accrued holiday time.

Note: Safety Management/Supervisory Unit may donate 50% of *accrued* holiday time as specified in their applicable MOU.

I understand that I am irrevocably forfeiting these hours, and when deducted from my balance, the leave hours shall be treated thereafter as time earned by the recipient at his/her regular rate of pay. A portion of these hours may be returned to me if the recipient returns to work with a MEL balance of more than 176 hours. Deduct the following hours from my accrued leave balance(s):

Vacation	Paid Time Off	Holiday	Administrative	Annual	Attorney	Compensatory

Note: Any changes/corrections to leave hours above must be initialed by the donating employee

RECIPIENT

Employee ID	Rcd No.	Last Name, First Name
Company		**Department**

Employee (Donor) Signature	Date

DEPARTMENT PAYROLL SPECIALIST VERIFICATION

I have verified that the above leave donation(s) conform to the requirements of the County's Medical Emergency Leave Policy. Enter the following FAS coding information for the donating employee.

Base Hourly Rate	SAP Cost Center Number	Internal Order	G/L Account
			51001316
Payroll Specialist Name (Print and Sign)		**Telephone**	**Date**

Office Use Only

DONOR							RECIPIENT
AVC	APT	AHL	AAD	AAN	AAL	ACT	AME
(-)	(-)	(-)	(-)	(-)	(-)	(-)	(+)

This document/form incorporates use of e-signatures in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

Reviewed By (Employee ID)	Date	Keyed By (Employee ID)	Date

DISTRIBUTION: Original - EBSD - Leaves Team (0440)