Compassionate Leave Donor Form

Employee: Complete and submit this form to the Risk & Benefits Team
Fax: 904.209.2414 **Email:** bccbenefits@sjcfl.us

I, _____, have read and understand the St. Johns County
(Print Name)
Compassionate Leave Policy (Administrative Code Section 408). I understand I must maintain a minimum leave balance following a donation and that my hours will be taken from my accrued leave.

I voluntarily donate ☐ hours (minimum of 8 hours) of my vacation leave for Compassionate Leave use for a:

Non-specified employee approved for Compassionate Leave hours

By signing below, I certify that I have not been directly or indirectly solicited or coerced into donating these hours.

_____ _____
Employee Signature Date Signed

_____ _____
Department Employee #

For Use by HR Department

Date Received		**Donor Minimum Leave Balance**	
Additional Notes			

cc: HR Department