THE OHIO STATE UNIVERSITY

Vacation Donation

Recipient Agreement

SECTION 1: RECIPIENT INFORMATION

Employee's Full Name: First _____ M.I. _____ Last _____ OSU Employee ID# (required) _____

Department _____ Title _____ FTE _____

Current Leave Balances: sick _____ **vacation** _____ **compensatory** _____

I am accepting: _____ **hours of donated vacation time**

SECTION 2: RECIPIENT STATEMENT OF UNDERSTANDING

I certify that I am not currently receiving any paid benefit as a result of my employment with the university, such as Select-Term or Long-Term Disability or Workers' Compensation. I understand that I am not eligible to simultaneously receive LTD, STD and/or Workers' Compensation while receiving pay from this donated time. I understand that converted sick hours paid to me will not exceed my normally scheduled work hours per pay period and will be counted concurrently as Family Medical Leave, if applicable. Additionally, I understand that compensation received under the Vacation Donation Program is considered taxable income.

☐ **Attached is documentation from the employee's physician that certifies that the employee has an illness or injury that is terminal or life threatening.**

_____ _____
Recipient Signature Date

_____ _____
Witness Signature/HR Representative Date

Approval:

_____ _____
Recipient Department Head Signature Date

_____ _____
College/VP Unit Designee Date