Shared Sick Leave Program – Membership Termination Form

I request to terminate my membership in the University System's Shared Sick Leave Program.

_________________________	_____________________	_________________________
Employee Name (Print)	Empl ID #	Department
_________________________	_____________________	_________________________
email	Phone #	Effective Date of Termination

I acknowledge that I have read and understand the program provisions as set forth in the Shared Sick Leave Program policy. I understand that any sick leave that I have donated before the membership is terminated will be forfeited.

_______________________________ _____________________________

Employee Signature Date

INSTRUCTIONS: Please complete and return this Termination of Membership form to the Office of Human Resources

FOR USE BY THE OFFICE OF HUMAN RESOURCES

Your termination of benefits has been received and processed. Thank you for your support of the Shared Sick Leave Program.

_______________________________ _____________________________

Program Administrator Signature Date