

Ohio Department of Medicaid  
**LEAVE DONATION APPLICATION**

<b>I. Donor Information</b>	
For Payroll Period Ending Date of	
Donating Employee ( <i>Last, First, Middle Initial</i> )	
Office	
Bureau	Section
<b>Number of Hours Donated</b>	<b>Type of Leave Donated</b>
	Vacation
	Sick Leave
	Personal Leave
	<b>TOTAL HOURS DONATED (Must equal at least 8 hours total) (MAY NOT EXCEED THE NUMBER OF HOURS DONEE IS SCHEDULED TO WORK IN A PAY PERIOD)</b>
<b>II. PERSON TO RECEIVE LEAVE</b>	
Person to Receive Leave (Must be employed by the same agency as the person donating leave.) ( <i>Last, First, Middle Initial</i> )	
Office	
Bureau	Section
<b>III. CERTIFICATION</b>	
I hereby certify that this request is made voluntarily. I was not coerced, intimidated or financially induced into donating leave. By signing I hereby relinquish all rights to the leave shown above and the benefits accruing to or attached to the same. I understand that the donation of leave is irrevocable and that no leave will be refunded to me. I certify that I will have a remaining balance of 80 hours or more of combined leave (sick, vacation and personal) after making this donation.	
Signature	Date

**Please return the completed form to:** Ohio Department of Medicaid  
 50 West Town Street, 5<sup>th</sup> Floor Attn: Payroll  
 Columbus, Ohio 43215-3414  
 ATTN: [MCD.Payroll\\_Benefits@medicaid.ohio.gov](mailto:MCD.Payroll_Benefits@medicaid.ohio.gov)