

STATE EMPLOYEES' LEAVE DONATION PROGRAM

APPEAL FORM

NAME: _____ SOCIAL SECURITY: _____

EMPLOYEE ADDRESS: _____

AGENCY: _____ AGENCY CODE: _____

DATE LEAVE TO BE EFFECTIVE: _____ HOURS: _____

In the space below, please indicate why you believe you were incorrectly denied the use of the donated leave.

Please provide a brief description of each document which you believe should be reviewed in connection with your appeal and indicate which of these documents is attached. For each document identified but not provided because it is unavailable to you, please identify the person who has custody and control of the document.

SIGNATURE: _____ DATE: _____