BOARD OF REGENTS OF
THE UNIVERSITY SYSTEM OF GEORGIA

Shared Sick Leave Program – Membership Termination Form

USG Institution Name: _____

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 policies. 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 your 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