BOARD OF REGENTS OF
THE UNIVERSITY SYSTEM OF GEORGIA

GEORGIA STATE UNIVERSITY

SHARED SICK LEAVE PROGRAM – MEMBERSHIP TERMINATION FORM

Employee Name: _____ Department: _____

Employee ID: _____ Hire Date: _____

Phone#: _____ Email: _____

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

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

PLEASE COMPLETE AND RETURN THIS FORM TO:
Georgia State University Benefits Office, 1 Park Place, Suite 330, Atlanta, GA 30303-3928 or by fax to (404)413-3324

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