



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
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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
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