



UNIVERSITY OF GEORGIA

Shared Sick Leave Program  
Membership Termination Form

\_\_\_\_\_  
Employee Name (Print)

\_\_\_\_\_  
UGA ID (81x number)

\_\_\_\_\_  
Employee date of birth

\_\_\_\_\_  
Department

\_\_\_\_\_  
UGA email

\_\_\_\_\_  
UGA phone #

\_\_\_\_\_  
Effective date of membership termination

I request to terminate my membership in the University System's Shared Sick Leave Program effective the date above. 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 I have donated before my membership is terminated will be forfeited.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**INSTRUCTIONS:** Please complete and return this Termination of Membership form to:

UGA Human Resources  
215 S. Jackson Street  
Athens, GA 30602  
Attn: Shared Sick Leave Program

**Or fax the form to:**  
706.542.7321