Shared Sick Leave Program – Leave Request Form

_____	_____	_____
Employee Name (Print)	Empl ID #	Department
_____	_____	
Email	Phone#	

I am requesting _____hours of Shared Leave under the terms specified in the Shared Sick Leave Program Policy.

I hereby acknowledge and certify the following:

- I have enclosed a completed physician's certification of a serious health condition for myself or an immediate family member.
- I agree that I will notify the Office of Human Resources if I am approved for benefits under Social Security Insurance or disability retirement prior to or after I begin receiving donated sick leave.
- I acknowledge that I have read and understand the program provision as set forth in the Shared Sick Leave Program policy.
- I understand that documentation of having a Power of Attorney is required with this form if I am acting on behalf of the employee recipient

_____	_____
Date Medical Condition Began	Date Medical Condition is Expected to End
_____	_____
Signature of Recipient or Authorized Representative	Date

INSTRUCTIONS: Please complete and return this recipient affidavit and the physicians certification form to the Office of Human Resources.

FOR USE BY THE OFFICE OF HUMAN RESOURCES

Type of Request: Initial Request _____ Secondary Request: _____

Status of Request: Leave Request Approved ____ Leave Request Not Approved ____

Your request for donated leave cannot be accepted due to the following reasons:

_____

_____

_____ _____

Shared Sick Leave Program Administrator Signature Date

If this request is denied and you wish to appeal this decision, submit your appeal along with this notice, in writing to the Office of Human Resources- Shared Sick Leave Program Administer.