



Human Resources

APPLICATION TO RECEIVE SHARED LEAVE

Employee Requesting Shared Leave: _____

Building/Dept: _____ Position: _____

Check if your position requires a substitute

Shared Leave Request Start Date: _____ End Date: _____

I suffer from an illness, injury, impairment, or physical or mental condition which is of an **extraordinary or severe nature**, and which has caused, or is likely to cause me to go on leave-without-pay status or terminate employment. Extraordinary or severe means serious or extreme and/or life threatening. WAC392-136A-020

A relative or household member is suffering from an illness, injury, impairment, or physical or mental condition which is of an **extraordinary or severe nature**, and which has caused, or is likely to cause me to go on leave-without-pay status or terminate employment.

Name of relative/household member: _____

My request for shared leave is for pregnancy, disability or parental leave.

I am a victim of domestic violence, sexual assault, or stalking as defined in RCW 41.04.655.

I have been called to service in the uniformed services.

Required certification is attached. For specific requirements, see back of form.

Employee Signature _____ Date _____

FOR HUMAN RESOURCES USE ONLY:

Received Time: _____ Date: _____

Total number of Days/Hours currently available for this employee:

____ (#) Sick Days/Hours Remaining

____ (#) Annual Leave Days/Hours Remaining

____ **TOTAL # Days/Shifts Remaining**

____ Request Approved ____ Request Denied

HR APPROVAL: _____ **Date:** _____

FOR PAYROLL SERVICES USE ONLY:

First Day Eligible to Receive Shared Leave:

Leave Transferred From: