



SHARED LEAVE REQUEST

REQUESTOR'S INFORMATION
Last Name: First Name, Middle Initial: Location (Facility/Office) Hours/Work Schedule:
Job Title: Supervisor's Name:
Is this request related to a job injury or illness? [] Yes [] No If yes, is your time-loss claim approved? [] Yes [] No [] N/A

Qualifying Reason (select one): Verification Requirement:
You or a relative/household member suffers from an extraordinary or severe illness, injury, impairment, or physical or mental condition. A "severe or extraordinary condition," is defined as serious or extreme and/or life threatening.
[] OR Parental leave per WAC 357-31-395
[] OR Pregnancy disability per WAC 537-31-395, as verified by a licensed physician or health care practitioner.
If this reason is selected, along with this request, a letter verifying the medical condition, completed by a licensed physician or health care practitioner, stating the reason for the request and the expected duration of the condition.
(maximum 90 days, may request extension or HR may waive the maximum based on information provided)
[] You have been called to service in the uniformed services.
For the purpose of participating in the shared leave program, a copy of your military orders verifying your required absence must accompany your request.
[] You have volunteered with a governmental agency or a nonprofit organization when a state of emergency has been declared within the United States.
Proof of acceptance of your offer to volunteer is required.
[] You are a victim of domestic violence, sexual assault, or stalking as defined in RCW 41.04.655.
Submit a police report, court order, or a statement from your attorney, clergy, medical professional or advocate, affidavit, etc. (Max 90 days, may request extension)

If I am approved to participate in the shared leave program, please send/post do not send or post an email message to all agency staff on my behalf requesting leave donations.
I request approval to participate in the Shared Leave Program for the reason selected above. My condition/situation will likely cause me, or has caused me, to take leave without pay or terminate my employment. My absence has depleted or will shortly deplete all of my available leave (accrued annual leave and applicable sick leave, personal holiday, paid military leave and/or compensatory). I understand any donated leave may only be used by me for the reason specified on the Share Leave Medical Certificate or for other verified qualifying reasons. If a time loss claim is approved at a later time, all leave received will be returned to the donors, and I will return any and all overpayments to the Department. As required, I have attached/submitted documentation verifying my qualifying reason. I understand if I plan to continue participation in the Share Leave Program I must submit a new shared leave request form every 90 days, unless stated otherwise by HR.
Date Signature

HUMAN RESOURCES REVIEW
Upon review of the employees personnel file, it appears this employee has abided by agency policy and/or applicable CBA regarding the use of sick and/or vacation leave? Yes No
Appropriate supporting documentation was submitted? Yes No Meets eligibility criteria. Yes No Type of leave needed: Intermittent Continuous Eligibility Date: End Date (max 90 days unless otherwise approved by HR):
Annual Leave Balance: Sick Leave Balance: Personal Holiday taken? Yes No *Comp. Leave Balance (Non-Rep EE Only): Date of Leave Balances: Comments:
Date: HR Consultant - Print Name: HR Consultant- Signature:

HUMAN RESOURCES DIRECTOR OR DESIGNEE
Approved Denied
If denied, please explain:
Date: Print Name: Signature: