

Shared Leave Request

Employee Name	Work Location	Leave Dates:		
Is this leave Continuous or Intermittent?	Is this request related to a job injury or illness?	Yes	No	
	If yes, is your time-loss claim approved?	Yes	No	N/A

Common Qualifying Reason (Select one) <i>See WAC 392-136A-030 for less qualifying reasons:</i>		Verification Requirement:
<input type="checkbox"/>	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.	If this reason is selected, along with this request, a licensed physician or health care practitioner must complete the Shared Leave Medical Verification Form 5406F3.
<input type="checkbox"/>	Pregnancy disability (per WAC 357-31-395) Expected Due Date _____	If this reason is selected, along with this request, a licensed physician or health care practitioner must complete the Shared Leave Medical Verification Form 5406F3.
<input type="checkbox"/>	Parental Leave (per WAC 357-31-395)	Verification of birth or placement of child. (may only be used for 16 weeks immediately following the birth or placement WAC 392-136A-045)
<input type="checkbox"/>	Other qualifying reason from WAC 392-136A-030 Reason: _____	Depends on reason listed.

You have the option to maintain up to 40 hours of sick and/or vacation leave under the following conditions:	
Up to 40 hours of SICK Leave	Self or Family illness, etc.; military service-connected injury for self or spouse; pregnancy-related condition; parental leave
Up to 40 hours of VACATION Leave (260-day employees only)	Self or Family illness, etc.; self-military service; military service-connected injury for self or spouse; volunteer service; victim of domestic violence, etc.; pregnancy-related condition; parental leave
I wish to maintain ____ (up to 40) hours of sick leave and/or ____ (up to 40) hours of vacation leave (260-day employees only).	

To solicit shared leave on your behalf, please select ONE of the following:	
<input type="checkbox"/>	I prefer the District to send a generic statement such as, "The employee listed below is qualified for Shared Leave per state law and District policy for ____ days."
<input type="checkbox"/>	I prefer the District to send the following statement on my behalf (may be edited by HR at its discretion):

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. I understand any donated leave may only be used by me for the reason specified in my request and accompanying verification. If a time loss claim is approved at a later date, I must return all overpayments to the District. As required, I have attached/submitted documentation verifying my qualifying reason. I understand I must submit a new shared leave request form at the beginning of each school year or if my reason for needing shared leave changes.

I also understand that all donations must be given voluntarily and that I will not coerce my co-workers into donating sick or vacation leave. **As donations are voluntary, they are not guaranteed.**

Signature	Date
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Executive Director of Human Resources or Designee			
Approved	Reason for Denial:		
Denied			
Name:	Signature:	Date:	