_____ _____ _____

EMPLOYEE NAME (PRINT) EMPLOYEE CWID# DEPARTMENT

_____ _____

EMAIL PHONE #

I am requesting _____ hours of Shared Sick Leave under the terms speci ed in the Shared Sick Leav Program Policy.

I hereby acknowledge and certify the following:

- I have enclosed a completed physician's certi cation of a serious health condition for myself or an immediate family member.
- I agree that I will notify the O ce of Human Resources if I am approved for other short term or long term income protection bene ts (such as SSI, Workers Compensation, etc.), 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

FOR USE BY THE OFFICE OF HUMAN RESOURCES

Type of Request: Initial Request: _____ Secondary Request: _____

Status of Request: Approved: _____ Not Approved: _____

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

_____ _____

SHARED SICK LEAVE PROGRAM ADMINISTRATOR SIGNATURE DATE

You may appeal the denial of this decision by submitting this notice along with a written statement to the O ce of Human Resources Shared Sick Leave Program Administrator.