
EMPLOYEE NAME (PRINT)

EMPLOYEE CWID#

DEPARTMENT

EMAIL

PHONE #

I am requesting _____ hours of Shared Sick 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 other short term or long term income protection benefits (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 Office of Human Resources Shared Sick Leave Program Administrator.